**MT DPHHS Healthcare Facilities Assessment**

**December 12, 2022**

**DRAFT REPORT**

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1. Executive Summary
2. Executive Summary | A&M Engagement

DPHHS engaged Alvarez & Marsal to conduct a comprehensive assessment and establish long-term sustainable operation plans for Montana’s seven state-run health care facilities.

**Assessment:**

***Key Activities***

* Assess compliance with regulations, quality standards, workers comp, and patient incidents
* Evaluate climate and culture
* Assess staffing structure, ratios, job descriptions, and scheduling
* Review organizational structure and back-office support functions
* Review key patient data, outcomes, and information on admissions and discharges
* Assess facility finances and rate structure
* Benchmark performance to peers

***Operational Support***

* Report financial status, condition, and operation of facilities
* Support oversight of day-to-day operations
* Support communications and change management
* Support quality initiatives

**Strategic Plans for Improvement**

* Update facility missions and visions
* Develop strategic plans to optimize utility of facilities and outcomes for patient populations
* Improve quality measures for safe delivery of care

1. Executive Summary | Recommendations (1 of 3)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ID** | **OBSERVATIONS** | **RECOMMENDATIONS** |
| **Healthcare Facilities Division** | **1.1** | *Significant changes are needed to implement recommendations.* | Stand up Transformation Management Office. |
| **1.2** | *There is a lack of accountability and clinical oversight at the facilities.* | Hire clinical and operational leadership to improve safety and quality, to include: Deputy Chief Healthcare Officer, Chief Medical Officer, Chief Nursing Officer, Chief Clinical Officer, and Quality Managers. |
| **1.3** | *There is an overreliance on certain treatment modalities.* | Implement Medical Staff function for ongoing and focused professional practice evaluation, peer review, credentialing, and privileging. |
| **1.4** | *Paper charting makes data collection difficult and creates patient safety risks.* | Implement a modern electronic health records system to improve patient outcomes and data sharing with providers. |
| **1.5** | *Competency at performing job duties is not evaluated before placing new staff in patient care areas.* | Develop competency-based job descriptions and review processes for direct care staff. |
| **1.6** | *Staff are not receiving adequate professional development opportunities and facilities are not meeting mandatory training requirements.* | Establish a governance system to oversee training programs and implement a learning management system to improve training compliance, career tracking, and professional development. |
| **1.7** | *There are significant vacancies for direct patient care positions, and the applicant pool is further limited due to the geographic location of the facilities.* | Update recruitment strategies and conduct a hiring blitz for nursing and direct service professional positions. Assess the feasibility of staff recruitment and retention strategies, including: hiring, retention, and referral bonuses; apprenticeship programs; high school / college student career pipelines; and academic hospital designations. |
| **1.8** | *Per diem rates and spend on travel nursing has significantly increased.* | Consolidate temporary contracted services spend and recompete staffing contracts to reduce costs and complexity of administration. |
| **1.9** | *Facilities are not actively managing expenses, and the division was overall significantly over budget in FY22.* | Implement active budget, contract, and revenue management processes to control costs. |
| **1.10** | *Facilities are not staffed to benchmark.* | Update staffing plans so that facilities are staffed to acuity and need, as appropriate. |
| **1.11** | *Facilities “feel” institutional and are not home-like.* | Purchase furnishings and other physical assets to improve therapeutic environment. |
| **1.12** | *Recent wage increases are not competitive enough to attract new employees.* | Increase wages to market rates to help recruit and retain employees. |

1. Executive Summary | Recommendations (2 of 3)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ID** | **OBSERVATIONS** | **RECOMMENDATIONS** |
| **Montana State Hospital** | **2.1** | *Patients in the Spratt unit are not being prepared for discharge and there are opportunities to improve delivery of care.* | Close Spratt (geriatric psychiatric unit) and transfer patients to Montana Mental Health Nursing Care Center and community providers. Repurpose these beds for hospital use. |
| **2.2** | *Average lengths of stay in units E and Spratt are too long and there is limited active planning for discharge.* | Implement case management model to prepare patients for discharge on admission and based on their projected length of stay and acuity. |
| **2.3** | *High acuity patients are intermixed with lower acuity patients.* | Restructure patient placement by acuity and their individual needs so that highest levels of care are provided in A and Galen, with step down units through B, D, E, Spratt, and group homes to improve care delivery. |
| **2.4** | *There is limited active treatment and treatment areas, gym, etc. are not fully operational.* | Develop appropriate policy for delivery of active treatment. Restart therapeutic programming impacted by the pandemic. |
| **2.5** | *MSH cannot refuse inappropriate forensic admissions due to statutory criteria.* | Change forensic statutory criteria for admission and discharge to mirror civil statutory criteria so that MSH is not required to accept patients that do not meet admission criteria. |
| **2.6** | *MSH has lost revenue with CMS de-certification.* | Seek CMS re-certification and then CARF or Joint Commission accreditation to improve quality oversight. |
| **2.7** | *MSH is a safety net for gaps in the behavioral health continuum of care and there is a significant wait for admission within the jail system.* | Improve Montana’s long-term delivery of care by building two new, regional, private behavioral healthcare settings that complement and support MSH and the other state-run facilities in large population areas. |
| **Montana Mental Health Nursing Care Center** | **3.1** | *MMHNCC has licensed beds that cannot be filled because they were repurposed during COVID.* | Build out infirmary as secured memory unit to place patients from Spratt. |
| **3.2** | *There is an overreliance on certain treatment modalities and out-of-date practice guidelines (e.g., psychotropics).* | Update standards of practice and ordering protocols to meet each patient’s needs. |
| **3.3** | *Patients were observed without appropriate end-of-life care.* | Contract with licensed hospice organization and develop end-of-life care policies aligned to modern practices. |
| **3.4** | *Facility administrator has 13 direct reports.* | Restructure operations to improve communications and patient outcomes. |
| **3.5** | *There are not clear policies & procedures surrounding admissions and discharges at MMHNCC.* | Develop person-centered admissions and discharge policies based on acuity and need. |

1. Executive Summary | Recommendations (3 of 3)

|  |  |  |  |
| --- | --- | --- | --- |
|  | **ID** | **OBSERVATIONS** | **RECOMMENDATIONS** |
| **Intensive Behavior Center** | **4.1** | *There is limited active treatment and community readiness. The state lacks the ability to implement and manage a short-term intensive treatment facility, licensed as an ICF/IID.* | Take immediate action to improve quality of care and align practices with federal ICF regulations, which may include having a private vendor run the facility. Additional actions to improve quality of care include more active treatment, modernized treatment plans, enhanced treatment areas, and improve integration within the local community. Update policies and procedures based on National Association for the Dually Diagnosed standards. |
| **4.2** | *Individuals are not transitioning back into the community.* | Update the discharge planning process to include person-centered practices (e.g., Charting the LifeCourse) and active transition planning with the provider community. |
| **4.3** | *IBC is not fulfilling intended purpose in continuum of care. The state lacks the infrastructure to provide intensive treatment services to people with intellectual and developmental disabilities at IBC. The existing facility also prevents the state from obtaining certification as an ICF/IID which would allow it to bring in a federal match for services.* | Implement a true short-term, intensive, private treatment facility certified as an intermediate care facility for individuals with intellectual and developmental disabilities (ICF/IID) as an alternative to IBC, to ensure enhanced quality of service and oversight and secure a federal match to operate the new program. This new program would replace the need for the current services provided at IBC, allowing for closure of the facility over the next 2-3 years. |
| **Montana Chemical Dependency Center** | **5.1** | *There is not enough demand based on prior years census. Occupancy rate is below 50% and there is no waiting list.* | Re-evaluate need for state-run acute care substance use disorder (SUD) beds given the broader SUD network capacity and demand trends. Engage with provider and community partners to increase referrals, improve census, and increase revenue. |
| **5.2** | *Barriers to admission deter some patients from seeking treatment.* | Receive patients in facility double rooms and update criteria for admission and discharge to allow for comorbidities and admissions within 48 hours. |

*Notes:1. Because our observations and ultimate recommendations regarding the three Montana Veterans Homes are covered in the recommendations for the overall Healthcare Facilities Division, we have not included separate recommendations for CFMVH, SWMVH, or EMVH.*

1. Overview of State-Run Health Care Facilities
2. Overview | Montana’s State-run Healthcare Facilities & Continuum of Care

A&M reviewed Montana’s behavioral health, aging, and intellectual and developmental disabilities systems to understand the role that the State’s facilities play in the broader continuum of care.

*Supporting people as they age, from assistance with daily living to specialized, long-term care and memory support*

*Supporting people with mental illnesses or substance use disorders, from outpatient support to crisis intervention and hospitalization*

*Supporting people with intellectual and/or developmental disabilities*

**STATE-RUN HEALTHCARE FACILITIES**

1. Montana State Hospital
2. Montana Mental Health Nursing Care Center
3. Montana Chemical Dependency Center
4. Intensive Behavior Center
5. Montana Veterans Homes – Columbia Falls

**CONTRACTOR-RUN HEALTHCARE FACILITIES**

1. Eastern Montana Veterans Home
2. Southwestern Montana Veterans Home

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Senior & Long-Term Care** | **(*Supporting people as they age, from assistance with daily living to specialized, long-term care and memory support)*** | 1. Montana State Hospital | 2. Montana Mental Health Nursing Care Center | 5. Intensive Behavior Center | 6. Intensive Behavior Center | 7. Eastern Montana Veterans Home |
| **Behavioral Health** | **(*Supporting people with mental illnesses or substance use disorders, from outpatient support to crisis intervention and hospitalization)*** | 1. Montana State Hospital | 2. Montana Mental Health Nursing Care Center | 3. Montana Chemical Dependency Center |  |  |
| **Intellectual & Developmental Disabilities** | **(*Supporting people with intellectual and/or developmental disabilities)*** | 1. Montana State Hospital | 4. Intensive Behavior Center |  |  |  |

1. Overview | State-run Healthcare Facilities Today

There are seven state-run health care facilities across the behavioral health continuum in Montana. Five are directly run by the state, while two of the veterans' homes (Eastern Montana Veterans Home and Southwestern Montana Veterans Home) are contracted out to state partners.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility** | **Location** | **License Type** | **Licensed Beds** | **Average Daily Census (FY22)** | **Occupancy Rate** | **State Operated** | **Contractor Operated** |
| Montana State Hospital | Warm Springs | Hospital & Mental Health Center | 270 | 206 | 76% | X |  |
| Montana Mental Health Nursing Care Center | Lewistown | Long Term Care | 117 | 73 | 62% | X |  |
| Intensive Behavior Center | Boulder | Intermediate Care Facility for the Developmentally Disabled | 12 | 10 | 82% | X |  |
| Montana Chemical Dependency Center | Butte | Inpatient Chemical Dependency Treatment | 48 | 21 | 43% | X |  |
| Montana Veterans Home – Columbia Falls | Columbia Falls | Long Term Care | 117 | 72 | 62% | X |  |
| Eastern Montana Veterans Home | Glendive | Long Term Care | 80 | 53 | 66% |  | X |
| Southwestern Montana Veterans Home | Butte | Long Term Care | 36 | 28 | 79% |  | X |
|  |  | **Total** | **680** | **463** | **68%** |  |  |

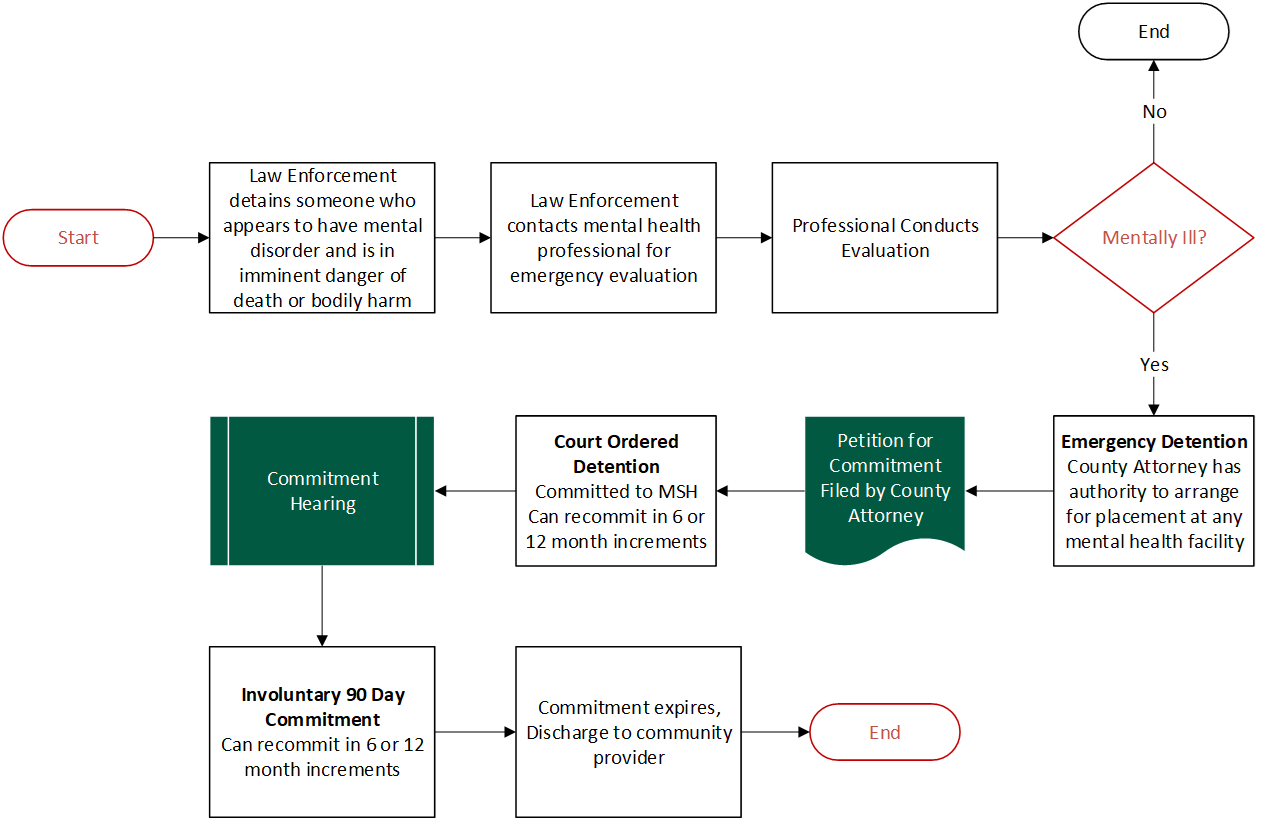
1. Overview | Montana State Hospital

Montana State Hospital (MSH) provides inpatient psychiatric treatment for adults with serious mental illness on civil or forensic commitment. MSH is codified in [MCA 53-21-601](https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0060/section_0010/0530-0210-0060-0010.html).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Unit** | **Purpose** | **License Type** | **Lic. Beds** | **Avg Census**  **(August 2022)** | **Setting Description** | **Patient Population** | **Length of Stay (Years)** | **Avg Patient Age** |
| **A** | Admissions – for stabilization and co-occurring disorders | Hospital | 31 | 13 | Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms | Civil commitment | Average: 0.2  Longest: 1.8 | 45 |
| **B** | Admissions – for stabilization and co-occurring disorders | Hospital | 26 | 12 | Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms | Civil commitment | Average: 0.2  Longest: 1.1 | 43 |
| **D** | Management of Legal Issues | Hospital | 32 | 32 | Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms | Forensic commitment | Average: 2.6  Longest: 14.5 | 43 |
| **E** | Social and Independent Living Skills | Hospital | 25 | 19 | Secured, mixed gender, 2 beds per room, with common areas, outdoor yard, and seclusion rooms | Civil commitment | Average: 2.1  Longest: 11.5 | 48 |
| **Spratt** | Adaptive Living for Elderly | Hospital | 60 | 38 | Secured, mixed gender, 2 beds per room, with television area and enrichment room | Civil commitment | Average: 1.2  Longest: 6.3 | 67 |
| **Galen – Pod A** | Forensic Men’s | Mental Health Center | 24 | 20 | Jail-like facility, 1 bed per room | Forensic commitment | Average: 0.3  Longest: 1.4 | 46 |
| **Galen – Pod B** | Forensic Men’s | Mental Health Center | 24 | 21 | Jail-like facility, 1 bed per room | Forensic commitment | Average: 1.0  Longest: 18.4 | 43 |
| **Galen – Pod C** | Forensic Women’s | Mental Health Center | 6 | 4 | Jail-like facility, 1 bed per room | Forensic commitment | Average: 0.5  Longest: 1.2 | 27 |
| **Group Homes** | Transitional Living | Mental Health Center | 42 | 32 | Group home-like setting | Forensic commitment | Average: 5.2  Longest: 24.4 | 41 |

1. Overview | Montana State Hospital Civil Commitment Process

There are two primary commitment types to MSH: Civil and Forensic. The flow chart below outlines a high-level process for civil commitments, per [MCA 53-21](https://leg.mt.gov/bills/mca/title_0530/chapter_0210/parts_index.html), which accounted for 75% of admissions in SFY22 to MSH.



**Process 1:**

Start > Law Enforcement detains someone who appears to have mental disorder and is in imminent danger of death or bodily harm > Commitment Hearing > Law Enforcement contacts mental health professional for emergency evaluation > Professional Conducts Evaluation > Mentally Ill? > No > End

**Process 2:**

Start > Law Enforcement detains someone who appears to have mental disorder and is in imminent danger of death or bodily harm > Commitment Hearing > Law Enforcement contacts mental health professional for emergency evaluation > Professional Conducts Evaluation > Mentally Ill? > Yes > **Emergency Detention**: County Attorney has authority to arrange for placement at any mental health facility > Petition for Commitment Filed by County Attorney > **Court Ordered Detention:** Committed to MSH Can recommit in 6 or 12 month increments > Commitment Hearing > Involuntary 90 Day Commitment: Can recommit in 6 or 12 month increments > Commitment expires, Discharge to community provider > End

1. Overview | Montana State Hospital Forensic Commitment Process

There are two primary commitment types to MSH: Civil and Forensic. The flow chart below outlines a high-level process for forensic commitments, per [MCA 46-14](https://leg.mt.gov/bills/mca/title_0460/chapter_0140/parts_index.html), which accounted for 14% of admissions in SFY22 to MSH.

This is the process flow chart for forensic commitments to Montana State Hospital. A detailed description follows in the text below.

**Process 1:**

Start > Defendant suspected of committing a felony is in legal system > Question raised during proceedings about whether defendant has mental ability to proceed > Court Ordered Evaluation Judge orders evaluation at MSH or Community Evaluator > Wait for Opening at MSH (Months) > Admission to MSH > MSH Conducts Evaluation > Hearing > Unfit to Proceed Defendant committed to MSH for treatment and restoration of competency > Fit to Proceed? > No > Charges may be dismissed & new proceedings through civil commitment > End Go to Civil Commitment

**Process 2:**

Start > Defendant suspected of committing a felony is in legal system > Question raised during proceedings about whether defendant has mental ability to proceed > Court Ordered Evaluation Judge orders evaluation at MSH or Community Evaluator > Wait for Opening at MSH (Months) > Admission to MSH > MSH Conducts Evaluation > Hearing > Unfit to Proceed Defendant committed to MSH for treatment and restoration of competency > Fit to Proceed? > Yes > Proceed thru Legal System > Pre-Sentence Investigation and Evaluation Defendant committed to MSH for treatment and fitness to proceed > Sentencing > Guilty? > No > Not Guilty Mentally Ill Person committed to MSH, must have commitment hearing within 180 days > End Go to Civil Commitment

**Process 3:**

Start > Defendant suspected of committing a felony is in legal system > Question raised during proceedings about whether defendant has mental ability to proceed > Court Ordered Evaluation Judge orders evaluation at MSH or Community Evaluator > Wait for Opening at MSH (Months) > Admission to MSH > MSH Conducts Evaluation > Hearing > Unfit to Proceed Defendant committed to MSH for treatment and restoration of competency > Fit to Proceed? > Yes > Proceed thru Legal System > Pre-Sentence Investigation and Evaluation Defendant committed to MSH for treatment and fitness to proceed > Sentencing > Guilty? > Yes > Guilty But Mentally III Person committed to MSH, must have commitment hearing within 180 days > End Go to Jail

1. Overview | Montana State Hospital Admissions by Commitment Type, July 2021 to June 2022

Civil commitments made up the vast majority of admissions at MSH from July 2021 to June 2022 (75 percent). The average length of stay across all MSH admissions was 55 days. Forensic commitments, while accounting for only 14 percent of total admissions, had an average stay of 168 days at the facility. Tribal commitments are civil comments that come from tribal lands in the state. For more detailed data, see [Appendix A](#Appendix_A).

|  |  |  |  |
| --- | --- | --- | --- |
| **Commitment** | **Commit Type** | **Admissions** | **Average Length of Stay (Days)** |
| Court Ordered Detention | Civil | 408 | 33 |
| Involuntary 90 Day | Civil | 179 | 53 |
| Tribal | Tribal | 84 | 21 |
| Unfit to Proceed | Forensic | 57 | 153 |
| Court Ordered Evaluation | Forensic | 36 | 152 |
| Guilty But Mentally Ill | Forensic | 12 | 190 |
| Emergency Detention | Civil | 11 | 31 |
| Pre-Sentence Evaluation | Forensic | 6 | 268 |
| Institutional Transfer | Transfer | 1 | 154 |
| 10 Day Inter-Institutional Transfer | Transfer | 1 | 9 |
| Not Guilty Mentally Ill | Forensic | 1 | 289 |
| **Subtotals** | **Civil** | **598** | **40** |
| **Forensic** | **112** | **168** |
| **Tribal** | **84** | **21** |
| **Transfer** | **2** | **85** |
| **Total** | **All** | **796** | **55**1 |

*Notes: 1. The average length of stay total was calculated as a weighted average based on the proportion of admissions of that commitment type to the total number of admissions at MSH*

**Table: Breakdown of Commitment Types at MSH July 2021 to June 2022**

|  |  |
| --- | --- |
| **Commitment Types** | **Percentage Share** |
| Civil | 75% |
| Forensic | 14% |
| Tribal | 11% |
| Transfer | <1% |

1. Overview | Montana Mental Health Nursing Care Center

Montana Mental Health Nursing Care Center (MMHNCC) provides long term care and treatment of persons who have mental disorders and who require a level of care not available in the community, but who cannot benefit from the intensive psychiatric treatment available at Montana State Hospital. MMHNCC is codified in [MCA 53-21-401](https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0040/section_0010/0530-0210-0040-0010.html).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Unit** | **Purpose** | **License Type** | **Lic. Beds** | **Avg Census**  **(August 2022)** | **Setting Description** | **Patient Population** | **Length of Stay (Years)** | **Avg. Patient Age** |
| **A Wing** | Independent –  Activities of Daily Living | Long Term Care | 25 | 18 | Nursing facility with 2 beds per room and with common areas and outdoor yard | Older Adults, behavioral health needs, rejected from other placements, forensic commitments | Average: 3.8 Longest: 10.5 | 65 |
| **D Wing** | Infirmary | Not Licensed | 0 | 0 | Used to be licensed by Dept of Corrections as Infirmary; secured unit could hold 25 beds. | N/A | N/A | N/A |
| **E Wing** | Secured | Long Term Care | 34 | 18 | Nursing facility with 2 beds per room and with common areas and outdoor yard | Older Adults, behavioral health needs, rejected from other placements | Average: 1.4 Longest: 5.2 | 67 |
| **F Wing** | Memory Care | Long Term Care | 28 | 12 | Nursing facility with 2 beds per room and with common areas and outdoor yard | Older Adults, behavioral health needs, rejected from other placements | Average: 2.9 Longest: 17.8 | 73 |
| **G Wing** | Heavy Care  (Temporary) | Long Term Care | 30 | 21 | Nursing facility with 2 beds per room and with common areas and outdoor yard | Older Adults, behavioral health needs, rejected from other placements | Average: 2.1 Longest: 7.7 | 72 |

MMHNCC patients are admitted as either civil or forensic commitments, and have been denied admissions at least three times by other nursing care facilities. As a result, MMHNCC serves a unique, distinct population whose needs differ from other state facilities or privately operated nursing facilities in Montana.

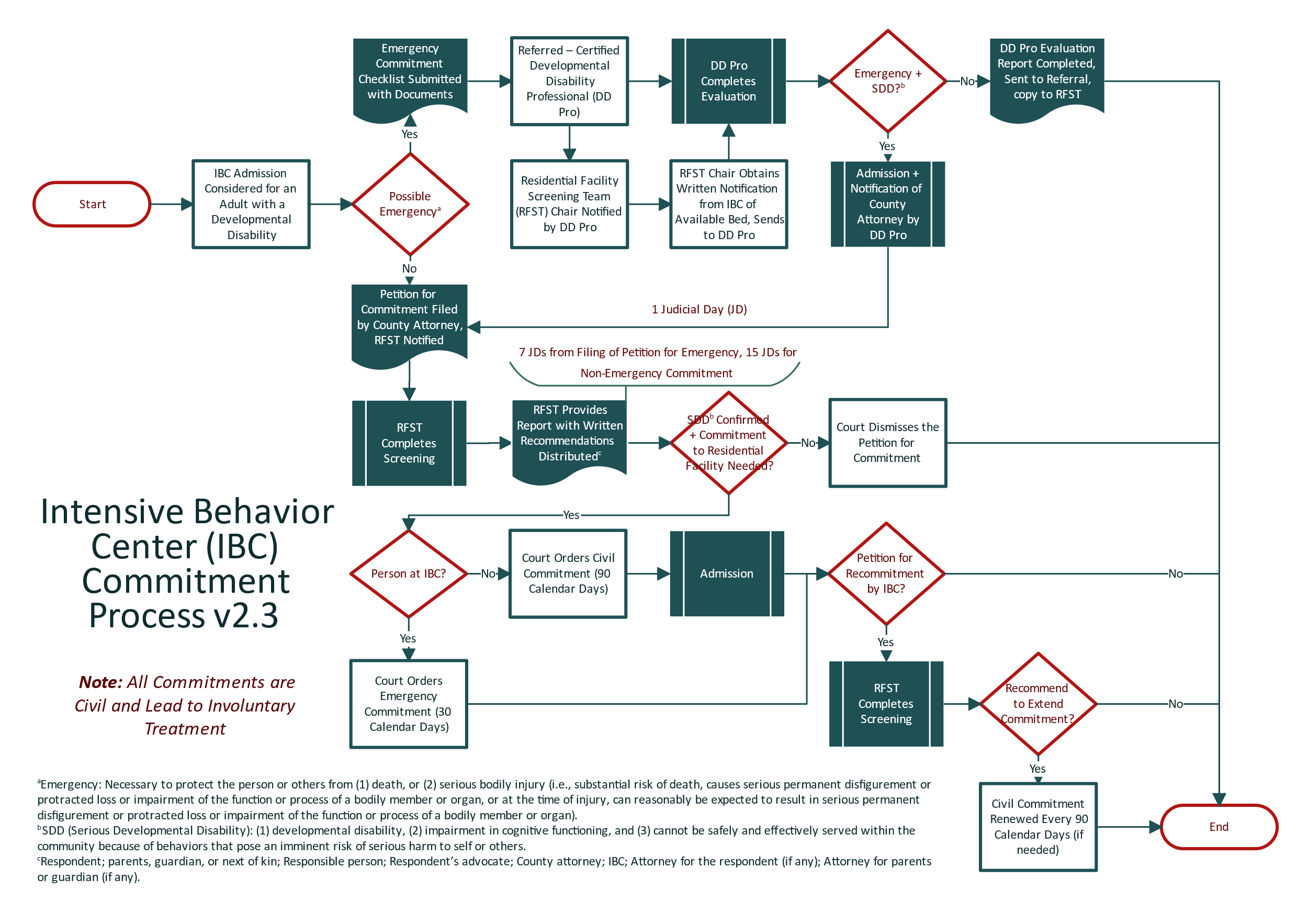
1. Overview | Intensive Behavior Center

The Intensive Behavior Center (IBC) treats patients with intellectual and developmental disabilities (I/DD) who need intensive treatment due to continuous or repeated behaviors that pose an imminent risk of serious harm to themselves or others. IBC is codified in [MCA 53-20-602](https://leg.mt.gov/bills/mca/title_0530/chapter_0200/part_0060/section_0020/0530-0200-0060-0020.html). Currently, IBC is licensed as an Intermediate Care Facility/Developmentally Disabled (ICF/DD) under [ARM 37.106.6](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.6), with no federal match for funds.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Cottage** | **Purpose** | **License Type** | **Lic. Beds** | **Avg Census**  **(August 2022)** | **Setting Description** | **Patient Population** | **Length of Stay (Years)** | **Avg Patient Age** |
| **A, B, and C** | Residential | Intermediate Care Facility for the Developmentally Disabled | 12 | 9 | Secured, each secure cottage has 4 beds in single rooms, with common area and secure outdoor yard. Kitchens and laundry available in each cottage through locked access. | Civil commitment | Average: 9.0  Longest: 22.8 | 34 |

1. Overview | Intensive Behavior Center Commitment Process

There are two primary commitment types to IBC: Civil and emergency. The flow chart below outlines a high-level process for these two types of commitments to IBC, codified in [MCA 53-20-602](https://leg.mt.gov/bills/mca/title_0530/chapter_0200/part_0060/section_0020/0530-0200-0060-0020.html).



**Process 1:**

Start > IBC Admission considered for an Adult with a Developmental Disability > Possible Emergency? > No > Petition for commitment Filed by County Attorney RFST Notified > RFST Completes Screening > RFST Provides Report with Written Recommendations Distributed\* > SDD Confirmed + Commitment to Residential Facility Needed? > No > Court Dismisses the Petition for Commitment > End

**Process 2:**

Start > IBC Admission considered for an Adult with a Developmental Disability > Possible Emergency? > No > Petition for commitment Filed by County Attorney RFST Notified > RFST Completes Screening > RFST Provides Report with Written Recommendations Distributed\* > SDD Confirmed + Commitment to Residential Facility Needed? > Yes > RFST Completes Screening > Recommended to Extend Commitment? > Yes > Civil Commitment Renewed Every 90 Calendar Days (if needed) > End

**Process 3:**

Start > IBC Admission considered for an Adult with a Developmental Disability > Possible Emergency? > Yes > Referred – certified development disability professional (DD Pro) > Residential Facility Screening Team (RFST) Chair Notified by DD Pro > RFST Chair Obtains Written Notification from IBC of Available Bed, Sends to DD Pro > DD Pro Completes Evaluation > Emergency SDD > No > End

**Process 4:**

Start > IBC Admission considered for an Adult with a Developmental Disability > Possible Emergency? > Yes > Referred – certified development disability professional (DD Pro) > Residential Facility Screening Team (RFST) Chair Notified by DD Pro > RFST Chair Obtains Written Notification from IBC of Available Bed, Sends to DD Pro > DD Pro Completes Evaluation > Emergency SDD > Yes > Admission + Notification of County Attorney by DD Pro > Petition for Commitment to Residential Facility Filled by County Attorney RFST Notified (Process 1).

1. Overview | Montana Chemical Dependency Center

The Montana Chemical Dependency Center (MCDC) provides detoxification, evaluation, treatment, referral, and rehabilitation services to patients who have substance use disorder. MCDC is codified in [MCA 53-21-603](https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0060/section_0030/0530-0210-0060-0030.html).

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Unit** | **Purpose** | **License Type** | **Lic. Beds** | **Avg Census**  **(August 2022)** | **Setting Description** | **Patient Population** | **Length of Stay** | **Avg Patient Age** |
| **A, B, and C** | Treatment of individuals with substance use disorder; detoxification, evaluation, treatment, referral, and rehabilitation services | Inpatient Chemical Dependency Treatment | 16 each  48 total | 11 | Building A has 8 detox beds with individual bathrooms and 8 regular treatment beds with four bathrooms. Buildings B&C have 16 beds each with two per room, and eight bathrooms. All buildings have one ADA room and bathroom. All three buildings doors are locked and require a key or fob to enter.  Each building has a kitchen, lounge area, laundry room, group room, phone room, and staff offices. There is one nursing station and one med room in each building as well. B&C building each have a fitness room. | Voluntary commitment | 19 days | 37 |

1. Overview | Montana Veterans Home: Columbia Falls, Eastern, and Southwestern

There are three veterans homes in the state of Montana. One, in Columbia Falls, is state-run, while the other two in Eastern and Southwestern Montana are run by contracted state partners. Notably, the waitlist at Columbia Falls is significantly higher than the other two veterans homes.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Unit** | **Purpose** | **License Type** | **Lic. Beds** | **Avg Census**  **(August 2022)** | **Setting Description** | **Patient Population** | **Length of Stay (Years)** | **Avg Patient Age** | **Waitlist (August 2022)** |
| **Columbia Falls Montana Veterans Home** | | | | | | | | |  |
| **1** | Intermediate or skilled nursing home care | Long Term Care | 40 | 16 | Montana Veterans Home – Nursing Home/Skilled nursing facility | Honorably discharged veterans or their spouses | 4.3 | 83 | 191 |
| **2** | Intermediate or skilled nursing home care | Long Term Care | 50 | 28 | Montana Veterans Home – Nursing Home/Skilled nursing facility | Honorably discharged veterans or their spouses | 4.3 | 83 |
| **3** | Dementia/Memory care - Intermediate or skilled nursing home care | Long Term Care | 15 | 11 | Montana Veterans Home – Nursing Home/Skilled nursing facility | Honorably discharged veterans or their spouses | 4.3 | 83 |
| **4** | Domiciliary – independent living | Long Term Care | 12 | 7 | Montana Veterans Home – Retirement Home - independent living | Honorably discharged veterans or their spouses | 2.8 | 85 |
| **Eastern Montana Veterans Home** | | | | | | | | | |
| **A/B** | Intermediate & Skilled nursing home care; 1 isolation room | Long Term Care | 34 | 30 | Other than 1 private room all rooms are double occupancy with 2 rooms sharing 1 bathroom | Male and female veterans and several female spouses of veterans with varied physical needs | 1-5 years | 70-80 | 0 |
| **C/D** | Intermediate & Skilled nursing home care; 1 isolation room | Long Term Care | 29 | 14 | Other than 1 private room all rooms are double occupancy with 2 rooms sharing 1 bathroom | All male veterans of varied physical needs | 1-5 years | 70-80 |
| **SCU** | Memory Care | Long Term Care | 16 | 14 | Secured unit all double occupancy rooms with 2 rooms sharing a bathroom; day room and enclosed courtyard available | Male and female residents living with advanced dementia and multiple with behaviors | 1-5 years | 70-80 |
| **Southwestern Montana Veterans Home** | | | | | | | | |  |
| **1** | Skilled Nursing | Long Term Care | 12 | 12 | Each Cottage is set up with 12 single occupancy bedrooms and 12 attached bathrooms. There is also a Spa Room (Tub Room) and Community bathroom in each Cottage. | Voluntary | 1 year | 80 | 34 |
| **2** | Skilled Nursing | Long Term Care | 12 | 11 | Voluntary | 1 year | 84 |
| **3** | Skilled Nursing | Long Term Care | 12 | 12 | Voluntary | 1 year | 78 |
| **4** | Skilled Nursing – Memory Care Unit | Long Term Care | 12 | 8 | Voluntary | 1 year | 79 |
| **5** | Opening later in 2023 | | | | | | | |

1. Peer State Analysis
2. Peer State Analysis | Approach

A&M conducted research into the broader service delivery systems of Montana’s peer states. The goal is to identify opportunities and lessons from strengths and weaknesses of these similarly situated states.

**Step 1: Develop Selection Model**

* Demographics, state expenditures, and mental healthcare need data was pulled from Census Bureau and Health Resources and Services Administration (HRSA) datasets.
* Variables were weighted to create a model that quantified US states’ similarity to Montana.

**Step 2: Identify Five Peer States**

* Our model outputted, in order of similarity to Montana, North Dakota, South Dakota, Alaska, Idaho, and Wyoming as Montana’s peer states.
* Input from DPHHS leadership was incorporated before moving forward with the peer states selected by the model.

**Step 3: Conduct Peer Analysis**

* Quantitative and qualitative data was pulled on peer states’ behavioral health and broader healthcare delivery systems.
* Data was categorized into behavioral health background statistics, state hospital statistics, community-based care statistics, crisis response, and legislative comparison.

1. Peer State Analysis | Background Statistics (1 of 3)

Montana, like all its peer states, has higher suicide rates than the national average. Additionally, Montana has the highest average poor mental health days3 of its peer states, which is slightly higher than the national average.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Behavioral Health Outcomes Statistics** | | |
| **State** | **Suicide Rate (per 100k people)1** | **Adult Any Mental Illness (AMI) Rate2** | **Average Poor Mental Health (MH) days in past 30 days3** |
| North Dakota | 18.2 | 20.5% | 3.7 |
| South Dakota | 21.0 | 18.3% | 3.7 |
| Alaska | 27.5 | 21.5% | 3.9 |
| Idaho | 23.2 | 22.5% | 4.4 |
| Wyoming | 30.5 | 22.6% | 4.1 |
| **Montana** | **26.1** | **20.8%** | **4.6** |
| **National Average** | **14.0** | **19.9%** | **4.5** |

*Notes: 1. CDC National Center for Health Statistics (2020)*

*2.**Mental Health America (2022)*

*3. County Health Rankings (2022) – average number of self-reported mentally unhealthy days in the past 30 days (age-adjusted)*

1. Peer State Analysis | Background Statistics (2 of 3)

In comparison to peer states, Montana has the fewest residents with mental illness (MI) reporting unmet treatment needs. Additionally, Montana’s State Mental Health Authority (SMHA) expenditures are higher than most of its peer states, as well as the national average.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Behavioral Health Treatment and Spending Statistics** | | | | |
| **State** | **Adults with MI reporting unmet need for treatment1** | **Population to MH providers ratio2** | **MH Provider Need Met3** | **SMHA Expenditures (per capita)4** | **Medicaid Long-term MH Facility Spend (per capita)5** |
| North Dakota | 25.6% | 470:1 | 18.8% | $115.82 | $25.73 |
| South Dakota | 25.3% | 500:1 | 16.8% | $98.52 | $3.31 |
| Alaska | 24.4% | 160:1 | 18.0% | $283.03 | $18.51 |
| Idaho | 29.1% | 440:1 | 29.8% | $48.80 | $2.08 |
| Wyoming | 24.5% | 270:1 | 47.1% | $102.18 | $13.49 |
| **Montana** | **21.5%** | **300:1** | **25.1%** | **$143.52** | **$23.18** |
| **Nationally** | **24.7%** | **350:1** | **28.1%** | **$138.49** | **$41.02** |

*Notes: 1. Mental Health America (2022)*

*2. County Health Rankings (2022)*

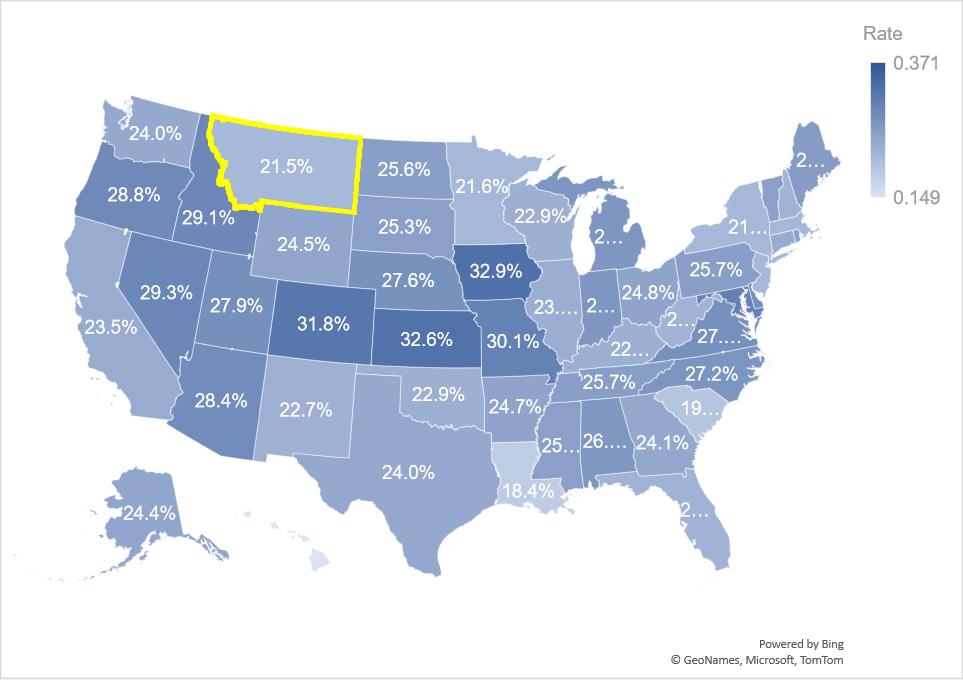
*3. Kaiser Family Foundation calculated from the Health Resources and Services Administration’s Health Professional Shortage Areas (2021)*

*4. SAMSHA Uniform Reporting System**(2020)*

*5. Kaiser Family Foundation (2020)*

1. Peer State Analysis | Background Statistics (3 of 3)

Of the adults with mental illness in Montana, 21.5 percent report having unmet needs for treatment. This is compares favorably to the national average (24.7%), and higher than each of Montana’s peer states. Only three states have lower rates of adults with unmet mental health needs (Hawaii, Louisiana, and South Carolina).



**Adults with mental illness reporting unmet needs for treatment**

*Notes: Data pulled from Mental Health America (2022)*

**Table:** **Percentage of** **Adults with mental illness reporting unmet needs for treatment - by US States**

|  |  |
| --- | --- |
| **State** | **Percentage** |
| Hawaii | 14.90% |
| Louisiana | 18.40% |
| South Carolina | 19.70% |
| Montana | 21.50% |
| Minnesota | 21.60% |
| New Jersey | 21.60% |
| Massachusetts | 21.70% |
| New York | 21.70% |
| West Virginia | 22.20% |
| Florida | 22.40% |
| New Hampshire | 22.40% |
| New Mexico | 22.70% |
| Kentucky | 22.90% |
| Oklahoma | 22.90% |
| Wisconsin | 22.90% |
| Illinois | 23.20% |
| California | 23.50% |
| Connecticut | 23.50% |
| Texas | 24.00% |
| Washington | 24.00% |
| Georgia | 24.10% |
| Alaska | 24.40% |
| Wyoming | 24.50% |
| Arkansas | 24.70% |
| Ohio | 24.80% |
| Vermont | 25.20% |
| Mississippi | 25.30% |
| South Dakota | 25.30% |
| Rhode Island | 25.40% |
| North Dakota | 25.60% |
| Pennsylvania | 25.70% |
| Tennessee | 25.70% |
| Maine | 25.90% |
| Alabama | 26.70% |
| Indiana | 26.80% |
| Michigan | 26.80% |
| North Carolina | 27.20% |
| Nebraska | 27.60% |
| Virginia | 27.70% |
| Utah | 27.90% |
| Delaware | 28.10% |
| Arizona | 28.40% |
| Oregon | 28.80% |
| Idaho | 29.10% |
| Nevada | 29.30% |
| Missouri | 30.10% |
| Maryland | 30.20% |
| Colorado | 31.80% |
| Kansas | 32.60% |
| Iowa | 32.90% |
| District of Columbia | 37.10% |

1. Peer State Analysis | State Hospital Statistics

MSH has much longer short-term stays than its peer states. In terms of 180-day readmission rate, Montana’s numbers are on the higher end of its peer states.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **State** | **# of State Operated MH Hospitals** | **Avg. Days of Stay (Discharged)1** | **Avg. Days of Stay**  **(<1 year)2** | **Avg. Days of Stay**  **(>1 year)3** | **Beds** | **Beds (per 100k people)** | **180-Day Readmission Rate4** |
| North Dakota | 1 | 114 | 53 | 3,152 | 108 | 14.2 | 34.2% |
| South Dakota | 1 | 63 | 63 | 1,324 | 133 | 15.1 | 19.4% |
| Alaska | 1 | 36 | 98 | 1,098 | 61 | 8.3 | 24.3% |
| Idaho | 2 | 56 | 56 | 852 | 165 | 9.4 | 16.0% |
| Wyoming | 1 | 113 | 89 | 1,780 | 122 | 21.0 | 11.9% |
| **Montana** | **1** | **148** | **117** | **1,485** | **270** | **25.4** | **23.8%** |

*Notes: \*As of 7/12/22*

*1, 2, 3, 4. SAMSHA Uniform Reporting System**(2020)*

1. Peer State Analysis | Community-Based Care Statistics

Montana has more Federally Qualified Health Centers (FQHCs) per 100k people than most of its peer states and is only one of two of its peer states to have any Certified Community Behavioral Health Clinic (CCBHCs). Additionally, while community utilization is high ER BH visits are also high, indicating community services can be improved.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **State** | **# of FQHCs** | **FQHCs (per 100k people)** | **CCBHC Status** | **# of CCBHCs** | **CCBHCs per 100k People** | **Community Utilization (per 1,000 people)1** | **ER BH Visits (per 100k people)2** |
| North Dakota | 5 | 0.66 | None | 0 | 0 | 18.5 | 2,111 |
| South Dakota | 4 | 0.45 | None | 0 | 0 | 19.4 | 1,268 |
| Alaska | 29 | 3.93 | Expansion Grants | 2 | 0.27 | 28.9 | No data |
| Idaho | 16 | 0.91 | None | 0 | 0 | 8.7 | No data |
| Wyoming | 8 | 1.38 | None | 0 | 0 | 28.2 | 1,505 |
| **Montana** | **15** | **1.41** | **Expansion Grants** | **3\*** | **0.28\*** | **68.80** | **2,048** |
| **Nationally** | **27**  **average FQHCs per state** | **0.46** | **N/A** | **10.5**  **Average CCBHCs per state** | **0.14** | **23.9** | **No data** |

*Notes: \*All of Montana’s CCBHCs are for substance use disorder (SUD) treatment*

*1.**SAMSHA Uniform Reporting System**(2020)*

*2. Agency for Healthcare Research and Quality (2019)*

1. Peer State Analysis | Legislative Comparison (1 of 3)

Compared to peer states, Montana has a short duration of custody for emergency evaluation, as well as limitations on who can petition an individual for emergency evaluation, impatient commitment, and outpatient commitment.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Emergency Evaluation** | **Access to court for citizens** | | | **Forced Medication** |
| **State** | **Duration of Emergency Custody** | **Who can petition for emergency evaluation?** | **Who can petition for inpatient commitment?** | **Who can petition for outpatient commitment?** | **Can the state provide involuntary medication orders?** |
| North Dakota | 4 business days | Any responsible adult | Any responsible adult | Any responsible adult | Yes |
| South Dakota | 5 days | Any responsible adult | Any responsible adult | Any responsible adult | Yes |
| Alaska | 72 hours | Any responsible adult | Only professionals | Only professionals | Yes |
| Idaho | 5 days | Only professionals | Any responsible adult | Any responsible adult | Yes |
| Wyoming | 72 hours | Any responsible adult | Any responsible adult | Any responsible adult | Yes |
| **Montana** | **1 business day** | **Only professionals** | **Only professionals** | **Only professionals** | **Yes** |
| **Best Practice\*** | **48-72 hours minimum** | **Any responsible adult** | **Any responsible adult** | **Any responsible adult** | **N/A** |

*Notes: \*According to the Treatment Advocacy Center*

**Responsible adult:** Some states authorize adults with specific relationships, such as parents, siblings, spouses, or guardians, to petition the court. Others authorize any responsible adult with the necessary knowledge of a person’s circumstances to do so.

**Professional:** A physician, psychiatrist, hospital admin, or law enforcement

1. Peer State Analysis | Legislative Comparison (2 of 3)

Montana and South Dakota are the only two states within this analysis without a psychiatric deterioration standard for inpatient civil commitment. Additionally, Montana, like almost all its peer states, has a procedural barrier to assisted outpatient treatment (AOT). **The next slide delves into these specific barriers.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Inpatient Civil Commitment** | | **Assisted Outpatient Treatment (AOT)** | |
| **State** | **Barriers to inpatient civil commitment?\*** | **Has psychiatric deterioration standard?** | **Statutory barriers to AOT?\*** | **Procedural barriers to AOT?\*** |
| North Dakota | No | Yes | No | Yes |
| South Dakota | No | No | No | Yes |
| Alaska | No | Yes | Yes | Yes |
| Idaho | No | Yes | No | Yes |
| Wyoming | Yes | Yes | Yes | No |
| **Montana** | **No** | **No** | **No** | **Yes** |

*Notes: \*According to the Treatment Advocacy Center*

1. Peer State Analysis | Legislative Comparison (3 of 3)

Montana and South Dakota are the only two states within this analysis without a psychiatric deterioration standard for inpatient civil commitment. An optimal psychiatric deterioration standard should enable the evaluator to consider the person’s treatment history in assessing the likelihood that the current episode of nontreatment will lead to psychiatric deterioration.

Additionally, Montana only has statutory or procedural barriers for AOT by not requiring a written treatment plan to be shared with courts. Sharing a treatment plan with courts has been shown to increase the success of AOT and prevent re-hospitalization and re-arrest.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **North Dakota** | **South Dakota** | **Alaska** | **Idaho** | **Wyoming** | **Montana** |
| **Has procedural barriers to AOT:**   * Written treatment plan not required to be shared with courts | **Doesn’t have a psychiatric deterioration standard**  **Has procedural barriers to AOT:**   * Written treatment plan not required to be shared with courts | **Has statutory barriers to AOT:**   * Patient must refuse treatment or affirmatively agree   **Has procedural barriers to AOT:**   * Written treatment plan not required to be shared with courts * No nonadherence procedure | **Has procedural barriers to AOT:**   * Written treatment plan not required to be shared with courts | **Has barriers to inpatient civil commitment:**   * Requires imminent harm and endangerment due to grave disability * Requires family/friends to refuse assistance   **Has statutory barriers to AOT:**   * Must be currently unstable for eligibility | **Doesn’t have a psychiatric deterioration standard**  **Has procedural barriers to AOT:**   * Written treatment plan not required to be shared with courts |
|  |  |  |  |  |  |

1. Peer State Analysis | Per Diem Charge Benchmarks

Except for Idaho, MSH per diem rates fall below those of Montana’s peer states – this is a sign that, compared to other states, Montana is underinvesting financially in its state-run facilities. Note, however, that Montana’s Medicaid Long-term MH Facility spend per capita is higher than its peer states, as noted in our [previous slides](#PeerStateAnalysis).

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility** | **Type** | **Licensed Beds** | **Per Diem Rate** |
| **Montana State Hospital** | **Psychiatric Hospital** | **270** | **$855 (2022)**1 |
| Alaska Psychiatric Institute | Psychiatric Hospital | 61 | $2,556 (2021) |
| North Dakota State Hospital | Psychiatric Hospital | 108 | $1,958 (2021) |
| South Dakota State Hospital | Psychiatric Hospital | 133 | $953 (2021) |
| Idaho State Hospital North | Psychiatric Hospital | 55 | $585 (2019) |
| Idaho State Hospital South | Psychiatric Hospital | 135 | $622 (2019) |
| Wyoming State Hospital | Psychiatric Hospital | 122 | $1311 (2021) |

*Notes: 1. MSH’s per diem rate in 2021 was $628 – the increase in 2022 is largely due to an increase in spend on traveling nurses.*

1. Facility Assessments
2. Assessment | Facility Census and Waitlist

With some facilities having consistently low census and others having high waitlist numbers, there is a clear need to make improvements and adjustments to ensure state-run facilities are providing support to individuals with behavioral health challenges to their full ability. For more detailed data, see [Appendix G](#AppendixG).

*Notes: 1. MSH data includes the Main Hospital, Forensic Unit, and Group Homes*

*2. SWMVH added 12 additional beds in July 2022*

**Table: Average Daily Census (%)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility Name** | **May** | **June** | **July** | **August** | **September** |
| **Overall** | 64% | 66% | 66% | 65% | 65% |
| **MSH** | 70% | 73% | 74% | 73% | 74% |
| **MMHNCC** | 59% | 58% | 57% | 58% | 57% |
| **IBC** | 75% | 75% | 75% | 75% | 83% |
| **MCDC** | 27% | 44% | 46% | 38% | 32% |
| **CFMVH** | 55% | 56% | 55% | 53% | 53% |
| **SWMVH** | 86% | 94% | 77% | 75% | 72% |
| **EMVH** | 71% | 73% | 73% | 73% | 73% |

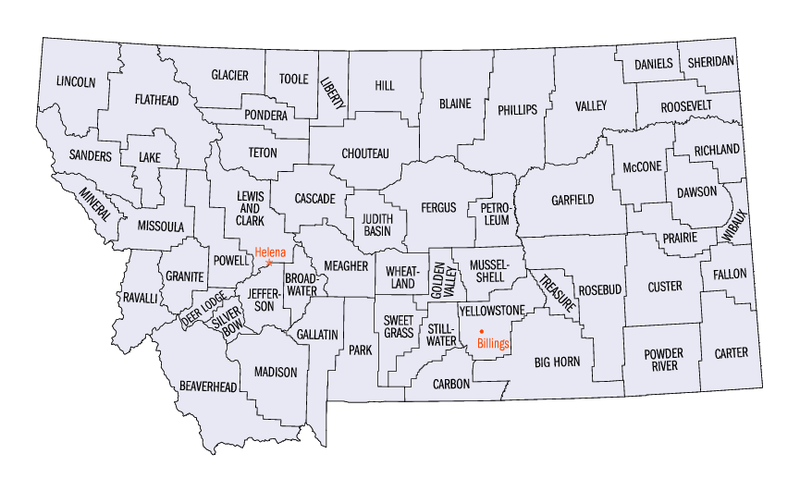
**Table: Waitlist #s at facilities**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility Name** | **May** | **June** | **July** | **August** | **September** |
| **MSH** | 40 | 38 | 44 | 39 | 42 |
| **MMHNCC** | 0 | 0 | 3 | 4 | 3 |
| **IBC** | 0 | 0 | 0 | 2 | 3 |
| **MCDC** | 15 | 0 | 0 | 0 | 0 |
| **CFMVH** | 203 | 198 | 196 | 196 | 204 |
| **SWMVH** | 31 | 40 | 32 | 34 | 32 |
| **EMVH** | 0 | 0 | 0 | 0 | 0 |

**Data Highlights:**

1. Average daily census across the network of state-run facilities has held steady around 65% over the last five months, with **MCDC consistently having the lowest census of the seven facilities.**
2. Waitlist numbers have remained **high at CFMVH** despite an average daily census of about 55% over the last five months.
3. Assessment | MSH Waitlist by County

As of August 25, 2022, **the forensic unit at MSH** had a 37-person waitlist, with an average wait time of 6 months, where most individuals are waiting in jail. Individuals from Missoula, Yellowstone, and Cascade County represent 41 percent of the waitlist.



**MSH Waitlisted Individuals by County (Forensic Unit)**

MSH facility location

|  |  |  |
| --- | --- | --- |
| **County** | **# on waitlist** | **Average wait time (months)** |
| **Big Horn** | 2 | 19 |
| **Cascade** | 5 | 6 |
| **Custer** | 1 | 4 |
| **Dawson** | 2 | 9 |
| **Flathead** | 3 | 3 |
| **Gallatin** | 2 | 4 |
| **Granite** | 2 | 3 |
| **Hill** | 1 | 5 |
| **Lake** | 1 | 3 |
| **Lewis & Clark** | 1 | 2 |
| **Lincoln** | 1 | 3 |
| **Missoula** | 5 | 8 |
| **Powell** | 4 | 10 |
| **Silver Bow** | 1 | 3 |
| **Toole** | 1 | 6 |
| **Yellowstone** | 5 | 5 |
| **Overall** | **37** | **6** |

1. Assessment | MCDC Census and the Montana SUD Facilities Landscape

MCDC is the only state-run Substance Use Disorder (SUD) facility that provides a 3.7 ASAM level of care, and is one of four total 3.7-level facilities across Montana. With 8 dedicated detox beds, MCDC accounts for **17.4** percent of the 3.7-level beds in the state.

|  |  |
| --- | --- |
| **Overall Data: Census and Licensed Beds Data – Montana SUD Facilities (All levels of ASAM care)** | |
| Number of Beds: Residential | 275 |
| Number of Beds: Inpatient | 192 |
| Total average daily census: Residential | 121 |
| Total average daily census: Inpatient | 13 |
| Average Waitlist (in weeks): Residential | 6 – 7 weeks |
| Average Waitlist (in weeks): Inpatient | 2 – 3 weeks |
| **Total number of licensed beds** | **467** |
| **Total average daily census across network (#)** | **134** |
| **Total average daily occupancy across network (%)** | **28.69%** |
| **Average waitlist (in weeks) across network** | **5 – 6 weeks** |

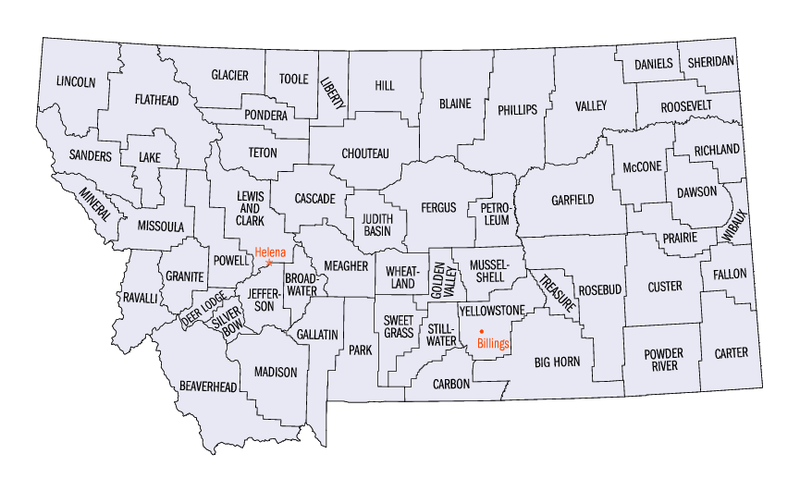
|  |  |
| --- | --- |
| **Benchmark Data: National Average vs. Montana** | |
| SUD beds per 100,000 adults **(national average)**3 | **42.7** |
| SUD beds per 100,000 adults **(Montana)** | **69.5** |

*Notes: 3. Source:* [*Psychiatric and Substance Use Disorder Bed Capacity, Need and Shortage Estimates in Sacramento County, California*](https://www.rand.org/content/dam/rand/pubs/research_reports/RRA1800/RRA1824-2/RAND_RRA1824-2.pdf)*, RAND Corporation (2022)*

Using the national average number of SUD beds per 100,000 adults as a benchmark, Montana should have a **minimum of 287 SUD beds**. With a total of 467 beds, Montana has **180 beds over the national average**.

Low census numbers indicate that many of these beds remain unoccupied – likely due to a combination of staffing issues, access, awareness, and/or demand.

**Geographic spread of 3.7 ASAM level-of-care facilities**



There are **four facilities** in the state of Montana that provide a 3.7 ASAM level-of-care, the highest level provided.

**3.7-level Facilities: Quick Stats**

* **Number of Facilities:** 4
* **Total number of beds**1**:** 42
* **Current waitlist times:** 3 – 7 days
* **Estimated census**2**:** ~ 55%

**Number of 3.7-level beds**

1. **Montana Chemical Dependency Center (Building A):** 8 beds
2. **Recovery Center of Missoula:** 16 beds1
3. **Rimrock Foundation Detoxification Center:** 12 beds
4. **RMTC, LLC – DBA Rocky Mountain Treatment:** 6 beds

*Notes: 1. The number of beds for the Recovery Center is a combination of beds for 3.5 and 3.7 level-of-care patients. These numbers were self-reported by the facilities.*

*2. The Recovery Center of Missoula did not provide their census information, and thus their census was estimated based on the lack of waitlist times*

1. Assessment | Facility Staffing Levels

A&M assessed facility staffing schedules for patient care areas to establish a baseline and compare to national and regional benchmarks. Facilities have robust staffing levels for their average daily censuses – however, there are high vacancy rates at facilities compared to the number of positions they have budgeted. Additional work is being done to determine what appropriate staffing levels should look like.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility** | **License Type** | **Licensed Beds** | **RN HPPD** | | **RN Skill Mix** | | **Total Nursing Care HPPD** | |
| ***Current*** | ***Benchmark*** | ***Current*** | ***Benchmark*** | ***Current*** | ***Benchmark*** |
| **MSH Main Hospital** | Hospital | 174 | 2.6 | 1.9 | 19% | 26% | 11.8 | 7.3 |
| **MSH Forensic** | Mental Health Center | 54 | 1.1 | 1.6 | 10% | 25% | 8.5 | 6.4 |
| **MSH Group Homes** | Mental Health Center | 42 | 0.4 | 1.6 | 6% | 25% | 4.4 | 6.4 |
| **IBC** | Intermediate Care Facility for the Developmentally Disabled | 12 | 2.6 | 1.9 | 7% | 32% | 23.1 | 6.0 |
| **MMHNCC** | Long Term Care | 117 | 1.2 | 0.8 | 24% | 21% | 5 | 3.8 |
| **MVH** | Long Term Care | 117 | 1.8 | 0.8 | 33% | 21% | 5.5 | 3.8 |
| **MCDC** | Inpatient Chemical Dependency Treatment | 48 | 2.2 | 1.0 | 33% | 25% | 4.3 | 3.84 |

**Hours Per Patient Day (HPPD)** is an endorsed measure by the National Quality Forum. For example, at MSH Main Hospital, each patient receives an average of 11.8 hours of nursing care in a 24-hour period (i.e., RN, Psych Tech, CNA). HPPD was calculated using average daily census and typical staffing schedules. Long term care benchmarks based on CMS data for 100 bed long term care facilities in Montana. All other benchmarks based on A&M proprietary information of similar behavioral health and forensic facilities. Generally, more acute patient populations require higher staffing levels, for example MMHNCC provides higher levels of care compared to other nursing facilities.

1. Assessment | Staff Vacancies by Facilities: 10-Year Snapshot

There has been an upward trend in vacancies among the facilities since 2015, with the greatest increase being seen in 2021 when vacancies increased by **58.8%**, partially fueled by the COVID-19 pandemic. Concurrently, there has been a **120% increase** in Montana’s average home value over the last decade, which poses challenges for recruiting and attracting talent to fill these vacancies.

*Notes: 1. Vacancies for each fiscal year are a point-in-time count from June of each year, with the exception of FY23 (see note below)*

*2. FY23 counts are as of September 8, 2022*

**Table: Vacancies at Montana State-Run Facilities: FY10 – FY231,2**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Facilities | 2010 | 2011 | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Combined | 63.49 | 83.43 | 86.73 | 64.6 | 59.04 | 70.15 | 99.64 | 112.12 | 164.97 | 170.54 | 130.45 | 207.13 | 320.56 | 337.1 |
| Intensive Behavioral Center | 21 | 14.69 | 23.98 | 14.25 | 28.94 | 30.5 | 45.13 | 46 | 85.82 | 51.31 | 11.6 | 13.91 | 34.91 | 37.6 |
| Montana Chemical I Dependency Center | 6 | 15 | 16 | 11 | 6 | 3 | 4 | 3.9 | 6.4 | 2.4 | 3.9 | 6.9 | 2.4 | 1.4 |
| Montana Mental Health Nursing Care Center | 4.89 | 11.99 | 12 | 10.55 | 11.1 | 17 | 7.2 | 9.67 | 15.7 | 32.93 | 12.7 | 15.87 | 32.9 | 34.4 |
| Montana State Hospital | 27 | 37.95 | 30.85 | 24 | 12.1 | 12.9 | 39.76 | 46.85 | 51.45 | 72.5 | 93.9 | 159.85 | 228.1 | 234.2 |
| Montana Veterans Home | 3.6 | 2.8 | 3.9 | 4.8 | 0.9 | 6.75 | 3.55 | 5.7 | 5.6 | 11.4 | 8.35 | 10.6 | 22.25 | 29.5 |

Wage increases went into effect between June 2021 and May 2022.

However, with competing influences of higher cost of living and the ongoing pandemic, alongside competition with private sector wages, there has been no visible positive impact on the level of vacancies.

|  |  |
| --- | --- |
| **Years** | **% change in vacancies over time** |
| FY11 | 31.40% |
| FY12 | 4.00% |
| FY13 | -25.50% |
| FY14 | -8.60% |
| FY15 | 18.80% |
| FY16 | 42.00% |
| FY17 | 12.50% |
| FY18 | 47.10% |
| FY19 | 3.40% |
| FY20 | -23.50% |
| FY21 | 58.80% |
| FY22 | 54.80% |
| FY232 | *5.20%* |

**Top 5 Vacant Positions across Facilities: August 2022**

|  |  |  |
| --- | --- | --- |
| **Position** | **# of Vacancies** | **% of Total Vacancies** |
| Psychiatric Technician | 111 | 31.1% |
| Registered Nurse (RN) | 47 | 13.2% |
| Certified Nurse Aide (CNA) | 46 | 12.9% |
| Direct Support Professional | 32 | 8.9% |
| Psychiatric Technician FMHT | 22 | 6.2% |

*Notes: 3. Source:* [*Zillow Home Value Index*](https://www.zillow.com/home-values/)*, last retrieved September 9, 2022*

*4. Home values are pulled from September of each respective year, with the exception of 2022, where the home value is as of July 31, 2022*

**Table: Home Value Trends: US vs. Montana, 2012 – 20223,4**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** |
| United States Avg Home Value | 167,000 | 180,000 | 190,000 | 199,000 | 210,000 | 223,000 | 237,000 | 247,000 | 261,000 | 311,000 | 355,000 |
| Montana Avg Home Value | 206,000 | 216,000 | 227,000 | 236,000 | 243,000 | 255,000 | 270,000 | 285,000 | 302,000 | 383,000 | 453,000 |
| Percent Change in Home Value: US |  | 7.80% | 5.60% | 4.70% | 5.50% | 6.20% | 6.30% | 4.20% | 5.70% | 19.20% | 14.10% |
| Percent Change in Home Value : MT |  | 4.90% | 5.10% | 4.00% | 3.00% | 4.90% | 5.90% | 5.60% | 6.00% | 26.80% | 18.30% |

Montana home values increased most significantly in in 2021 (by 26.8%) – **the same year Montana facilities saw the greatest increase in vacancies**.

1. Assessment | Staff Turnover and Reasons for Leaving

Since January 2020, there have been 768 separations at Montana state-run facilities, the majority due to employee personal reasons or career choice. However, in that same time period, there have only been 491 new hires or rehires, creating a **net loss of 277 staff** in the last 33 months.

*Notes 1.Data for 2022 is through September 30*

*2. Net change in staff is calculated by subtracting the number of separations by the number of hires and rehires in that time period*

**Table: Separations and Hires: Jan 2020 to Aug 2022**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Jan-Mar** | **Apr-Jun** | **Jul-Sept** | **Oct-Dec** | **Jan-Mar** | **Apr-Jun** | **Jul-Sept** | **Oct-Dec** | **Jan-Mar** | **Apr-Jun** | **Jul-Sept** |
| **MCDC** | 6 | 2 | 2 | 4 | 2 | 3 | 4 | 2 | 5 | 4 | 3 |
| **MVH** | 12 | 4 | 16 | 10 | 17 | 29 | 18 | 8 | 14 | 10 | 12 |
| **MSH** | 34 | 24 | 35 | 43 | 28 | 58 | 40 | 48 | 27 | 26 | 28 |
| **MMHNCC** | 6 | 9 | 7 | 10 | 6 | 7 | 12 | 11 | 14 | 9 | 5 |
| **IBC** | 8 | 9 | 8 | 5 | 14 | 14 | 9 | 8 | 6 | 5 | 8 |
| **Hires and Rehires** | 53 | 54 | 49 | 53 | 36 | 40 | 37 | 31 | 53 | 50 | 35 |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Time Period** | **2020** | | | | **2021** | | | | **2022** | | |
|  | **Jan – Mar** | **Apr – Jun** | **Jul – Sept** | **Oct – Dec** | **Jan – Mar** | **Apr – Jun** | **Jul – Sept** | **Oct – Dec** | **Jan – Mar** | **Apr – Jun** | **Jul – Sept** |
| **Net Change in Staff**2 | -13 | 6 | -19 | -19 | -31 | -71 | -46 | -46 | -13 | -4 | -21 |

|  |  |
| --- | --- |
| **Reason3** | **# of Separations** |
| **Personal Reasons** | **290** |
| **Career Choice** | **121** |
| For Cause | 90 |
| Retirement | 81 |
| Job Abandonment | 64 |
| Probationary Period | 47 |
| Relocation | 28 |
| End Assignment | 12 |
| Work Conditions | 10 |
| Family Reasons | 7 |
| More Pay | 5 |

*Notes: 3. Upon separation, employees are asked to select the most fitting option for their reason for leaving from a list. This list was created and approved by the Montana Department of Administration, and match up with the options available for the HR team to enter into SABHRS. SABHRS does not have the ability to track more than one option.*

**54% of separations** from January 2020 to August 2022 were due to personal reasons or a career choice3

**Qualitative Data Insights: Exit Interviews & Pay:** Our team received 21 complete exit interviews from two of the five facilities. Of these interviews, **57 percent** said they “strongly disagreed” with the statement that their salary was adequate. **43 percent** listed pay as a reason for leaving their role.

1. Assessment | Facilities Recruitment

The shortage of health care workers, including nurses, is not unique to Montana’s facilities – health care settings nationwide are grappling with staffing shortages, which have been worsened by the COVID-19 pandemic. However, as a frontier state, this shortage and the challenges associated with recruiting for these positions is acutely felt in Montana.

**The COVID-19 pandemic has exacerbated the existing health care worker shortage nationwide.** In the last two years of the “Great Resignation,” the healthcare field has lost an estimated 20 percent of its workforce, including 30 percent of nurses.1

**The location of Montana’s facilities, cost of living, and housing availability all impact the ability to recruit talent**. A study released by WalletHub in June 2022 showed Montana as the state with the second highest resignation rate over the last year, with a resignation rate of 3.69% from June 2021 to June 2022.2 Alaska had the highest resignation rate, at 4.18%, and Wyoming came in third at 3.69%. All three states face similar recruiting challenges as rural states with a large geographic spread.

**Staff turnover is a cause of even more staff turnover.** When staff leaves, it puts more stress and strain on the staff remaining. This causes even more burnout, and leads to additional staff turnover, creating a vicious cycle and a recruitment workload that is difficult for HR departments to keep up with.

**Tackling the staffing shortage in Montana’s facilities**

To navigate the unique challenges facing recruitment in Montana and in health care, facilities use a variety of recruitment channels to attract talent.

**Recruitment channels across facilities3**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility** | **State Recruiting System (SOMRS)** | **Job Sites (Indeed, LinkedIn, etc.)** | **Social Media** | **Montana State and Local Media** | **Word of Mouth** | **University-level recruitment** | **Job Fairs** | **Staffing agencies** |
| **MCDC** | ✓ |  | ✓ | ✓ |  |  |  |  |
| **MMHNCC** | ✓ |  |  | ✓ |  | ✓ | ✓ | ✓ |
| **MSH** |  | ✓ | ✓ |  |  |  | ✓ |  |
| **MVH-CF** | ✓ | ✓ |  | ✓ |  | ✓ |  |  |
| **SWMVH** |  | ✓ | ✓ |  | ✓ |  | ✓ |  |
| **IBC** |  |  |  | ✓ |  |  |  |  |
| **EMVH** |  | ✓ |  | ✓ |  |  | ✓ |  |

*1. Source:* [*Health Leaders Media*](https://www.healthleadersmedia.com/human-resources/great-resignations-toll-healthcare) *(March 2022)*

*2. Source:* [*WalletHub*](https://wallethub.com/edu/states-with-highest-job-resignation-rates/101077) *(July 2022)*

*3. Information about recruitment initiatives was provided directly by the facilities, and may not be fully comprehensive of all recruitment efforts occurring*

1. Assessment | Employee Safety: Workers’ Compensation Claims

Montana facilities workers’ compensations claims are, mostly, underperforming against national benchmarks, with only IBC showing significant improvement between FY21 and FY22. Most workers’ compensation claims in the last two fiscal years were for uses of force / assault.

**Facility Workers’ Comp Claims v. Benchmark**

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility** | **Fiscal Year** | **Claims Per 100 FTEs** | **Benchmark1** |
| **IBC** | 2021 | 174.2 | 7.9 |
|  | 2022 | 81.8 | 7.9 |
| **MVH** | 2021 | 22.8 | 7.9 |
|  | 2022 | 22.8 | 7.9 |
| **MMHNCC** | 2021 | 7.6 | 7.9 |
|  | 2022 | 10.4 | 7.9 |
| **MSH** | 2021 | 10.3 | 3.7 |
|  | 2022 | 7.7 | 3.7 |
| **MCDC** | 2021 | 0.0 | 7.9 |
|  | 2022 | 5.3 | 7.9 |

*Notes: 1. Benchmarks are based on OSHA’s 2020 average rate of nonfatal occupational injuries and illnesses for residential care facilities and hospitals, published November 2021. Source:* [*https://www.bls.gov/news.release/osh.t05.htm*](https://www.bls.gov/news.release/osh.t05.htm)

**Key Considerations for Next Steps and Recommendations**

* Target improvements at IBC, with the unique population in mind
* Lower claims MCDC may be due to a low staff to patient ratio at the facility
* Union agreements must be kept in mind as improvements and changes are made

**Table: Total Workers Comp Claims, FY21-22**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Use of Force/Assault** | **Slip Trip Fall** | **Lifting/Moving Person** | **Manual Material Handling** | **Struck Against** | **Biological Exposure** | **Other** | **Caught In/Under/ Between** | **Contact with Animal or Insect** | **Contact with Sharp Object** | **Cumulative e Trauma** | **Particles/ Material in Eye(s)** | **Physical Training** | **Recreation** | **Struck b Object** | **Thermal Exposure** |
| **IBC** | 140 | 12 | 0 | 2 | 3 | 0 | 3 | 0 | 1 | 0 | 0 | 2 | 1 | 2 | 3 | 0 |
| **MSH** | 44 | 16 | 5 | 12 | 4 | 2 | 1 | 2 | 0 | 0 | 4 | 1 | 3 | 0 | 2 | 0 |
| **MVH** | 10 | 14 | 15 | 7 | 2 | 3 | 4 | 2 | 0 | 3 | 1 | 0 | 0 | 0 | 4 | 3 |
| **MMHNCC** | 8 | 4 | 7 | 1 | 0 | 2 | 1 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 1 | 0 |
| **MCDC** | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |

1. Assessment | Patient Safety and Incident Tracking across State-Run Facilities

Incident tracking across facilities is inconsistent and lacks uniformity, with each facility tracking different types of incidents in different ways. Nevertheless, the number of reported incidents at facilities has steadily increased in 2022.

**Table: Incidents Across Facilities: 2022**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Facilities** | **January** | **February** | **March** | **April** | **May** | **June** | **July** |
| **SWMVH** | 1 | 5 | 1 | 1 |  | 1 | 2 |
| **MVH-CF** | 18 | 7 | 0 | 0 | 0 | 0 | 15 |
| **MSH** | 68 | 172 | 184 | 174 | 144 | 181 | 317 |
| **MMHNCC** | 58 | 41 | 59 | 39 | 48 | 25 | 46 |
| **MCDC** | 5 | 6 | 4 | 6 | 5 | 2 | 7 |
| **IBC** | 13 | 4 | 10 | 8 | 22 | 39 | 40 |
| **EMVH** | 28 | 32 | 31 | 36 | 37 | 57 | 60 |

There is a **lack of consistency** between the facilities in which incidents are tracked and how they are being tracked (for more detail, see [Appendix E](#AppendixE)).

The number of incidents have been increasing in 2022, with reported incidents jumping by **60 percent** from June to July this year.

**Inpatient Psychiatric Hospital Patient Safety v. National Average**

|  |  |  |
| --- | --- | --- |
| **State Hospital** | **Hours of Physical Restraint Use per Day1** | **Hours of Seclusion Use per Day1** |
| Alaska | 0.14 | 0.39 |
| Idaho (South) | 0.10 | 0.39 |
| North Dakota | 0.88 | 2.00 |
| South Dakota | 1.25 | 1.37 |
| **Montana (MSH)** | **0.26** | **2.13** |
| National Avg | 0.30 | 0.29 |

*Notes: 1. CMS Inpatient Psychiatric Facility Quality Measure Data - by Facility, published July 2022.   
Source:* [*https://data.cms.gov/provider-data/dataset/q9vs-r7wp*](https://data.cms.gov/provider-data/dataset/q9vs-r7wp)

**Nursing Home Patient Safety v. National Average**

|  |  |  |
| --- | --- | --- |
| **Facility** | **% of Residents with One or More Falls with Major Injury2** | **% of Residents Who Got an Antipsychotic Medication2** |
| **MMHNCC** | 7.7% | 69.3% |
| **MVH** | 8.8% | 16.3% |
| **EMVH** | 5.7% | 24.3% |
| **SWMVH** | 1.6% | 15.8% |
| National Avg | 3.4% | 14.5% |
| Montana Avg | 5.3% | 16.6% |

*Notes: 2. CMS Skilled Nursing Facility Quality Reporting Program - Provider Data, published August 2022. Source:* [*https://data.cms.gov/provider-data/dataset/fykj-qjee*](https://data.cms.gov/provider-data/dataset/fykj-qjee)

1. Assessment of Spending on Temporary Contractor Staff, 2023 YTD (Travel Nursing)

A&M has been working with facilities to analyze travel nursing spend and average traveler hourly wages. Overall traveler spend in calendar year 2022 is higher than in 2021. Facilities continue to face high vacancy rates and are using travel nursing to cover gaps in care. DPHHS will release an RFP next month to consolidate traveler contracts, with a goal to reduce administrative burden and obtain better pricing.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Traveler Hourly Wage2** | | | **Employee Base Wage + Benefits3** | | |
|  | **RN** | **LPN** | **CNA** | **RN** | **LPN** | **CNA** |
| **MSH** | $ 121.14 | $ 74.64 | $ 72.08 | $ 51.10 | $ 33.75 | $ 27.46 |
| **IBC** | $ 132.01 |  | $ 81.62 | $ 47.91 |  | $ 27.49 |
| **MCDC** | $ 121.00 |  |  | $ 47.03 |  | $ 25.68 |
| **MMHNCC** | $ 79.55 | $ 61.60 | $ 43.25 | $ 46.89 |  | $ 27.27 |
| **MVH** | $ 91.00 | $ 71.04 | $ 54.27 | $ 47.12 | $ 33.58 | $ 27.14 |
| **Facility Average** | **$ 110.05** | **$ 70.65** | **$ 62.27** | **$ 47.92** | **$ 33.66** | **$ 27.20** |
| Behavioral Health Facility Benchmark4 | | |  | $ 50.74 | $ 35.03 | $ 20.42 |
| Nursing Home Facility Benchmark5 | | |  | $ 44.41 | $ 33.68 | $ 21.01 |
| State of Montana 2022 Market Analysis6 | | |  | $ 47.27 | $ 33.45 | $ 26.69 |

*Notes: 1. We are working to improve data quality; date is either invoice date or month worked; in the future this will reflect month worked.*

*2. Average traveler hourly wage for the time period January 2022 to September 2022*

*3. Average state employee base wage based on SABHRS report obtained July 27, 2022, plus benefit packages value.*

*4. Hospital & Healthcare Compensation Service, Behavioral Health Salary & Benefits Report, 2022.*

*5. Hospital & Healthcare Compensation Service, Nursing Home Salary & Benefits Report, 2022.*

*6. State Human Resources (State HR) salary survey data, May 31, 2022.*

*Wages at MMHNCC and MVH are lower because free housing is provided to travelers.*

**Table: Traveler Spend – Jan 2020 to Sept 2022**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Jan-Mar 2020** | **Apr-Jun 2020** | **Jul-Sep 2020** | **Oct-Dec 2020** | **Jan-Mar 2021** | **Apr-Jun 2021** | **Jul-Sep 2021** | **Oct-Dec 2021** | **Jan-Mar 2022** | **Apr-Jun 2022** | **Jul-Sep 2022** |
| **MVH** |  |  |  |  |  |  |  |  | $12,545 | $40,089 | $152,576 |
| **MCDC** |  |  |  |  |  |  |  |  |  | $88,134 | $119,474 |
| **MMHNCC** |  |  |  |  |  |  |  |  | $214,281 | $417,893 | $546,349 |
| **IBC** |  |  |  |  |  |  |  |  | $836,529 | $1,679,404 | $1,283,263 |
| **MSH** | $1,405,285 | $1,591,808 | $1,654,213 | $1,591,936 | $2,644,726 | $3,083,199 | $3,948,693 | $5,245,486 | $8,809,208 | $11,543,812 | $12,489,050 |

**Table: Traveler Spend – Jul - Sept 2022**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Jun** | **Jul** | **Aug** | **Sep** |
| **MVH** | $32,889 | $73,297 | $59,715 | $19,564 |
| **MCDC** | $42,950 | $36,443 | $42,971 | $40,061 |
| **MMHNCC** | $147,834 | $166,466 | $189,942 | $227,465 |
| **IBC** | $589,271 | $507,963 | $359,439 | $415,861 |
| **MSH** | $5,230,699 | $4,039,455 | $4,306,559 | $4,143,035 |

|  |  |  |
| --- | --- | --- |
| **Facility** | **CY22 Traveler Spend** | **Vacancy Rate** |
| **MSH** | $ 32,842,069 | 45% |
| **IBC** | $ 3,799,196 | 67% |
| **MMHNCC** | $ 1,216,045 | 30% |
| **MCDC** | $207,608 | 4% |
| **MVH** | $205,210 | 21% |

1. Assessment | Required Training Compliance

In the June 2022 Climate and Culture Survey, employees reported low satisfaction with professional development. An audit of training compliance and course offerings revealed deficiencies at all facilities. Because of improvements to governance & compliance, the maturity rating has improved from red to green. **A&M is working with facilities to enhance practices and improve compliance.**

**Table: Training Compliance**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **MSH** | **MMHNCC** | **MCDC** | **MVH** | **IBC** |
| **Jun -22** | 14% | 67% | 91% | 74% | 66% |
| **Jul -22** | 70% | 74% | 91% | 74% | 80% |
| **Aug -22** | 77% | 72% | 91% | 68% | 79% |
| **Sep -22** | 89% | 88% | 97% | 76% | 97% |

**Montana State Hospital Training Notes:**

* MSH’s training program was significantly impacted by COVID, and they stopped delivering refresher training.
* Employees hired after October 2021 received onboarding training, but MSH was unable to provide documentation. The increase in training compliance from June to July is primarily because documentation was created.
* Refresher training has now restarted with compliance increasing from 14 to 77% in three months.

|  |  |  |  |
| --- | --- | --- | --- |
| **Component** | **Maturity** | **Findings** | **Best Practices** |
| People |  | * 1 of 5 facilities has dedicated training staff. * 5 of 5 facilities have staff assigned to deliver training on a part-time basis. * New performance evaluation system (Talent) includes individual goals for each employee. | * Facilities have a training program administrator and sufficient instructional resources. * Each employee has an individual learning plan. |
| Process |  | *Original State* – 62% Compliance across facilities   * Onboarding training processes exist at all facilities. Refresher training processes exist at 3 of 5 facilities.   ***Current State* – 76% Compliance across facilities**   * Onboarding and refresher training now occurring at all facilities. | * New employees receive training during onboarding according to job duty. * Employees receive annual training refreshers according to job duty. * Training is delivered using multiple modalities including online, classroom, and on the job. |
| Tools & Technology |  | *Original State*   * There are no supporting systems to track training compliance outside of spreadsheets. * Training records are inconsistently stored in employee files.   ***Current State***   * DPHHS Learning Management System (Moodle) being piloted at MCDC. | * Learning Management System tracks required trainings by job duty and individual employee compliance. |
| Governance & Compliance |  | *Original State*   * 2 of 5 facilities did not have training policies. 2 of 5 facilities training policies did not document required trainings by job duty. * There was no evidence that training compliance is being audited regularly.   ***Current State***   * *5 of 5 facilities have updated and comprehensive training policies.* * *Facilities now reporting to Division, compliance* is being audited monthly. | * Training policies outline required trainings by job duty, frequency of refresher training |

**Legend:**

*Maturity Rating indicates DPHHS performance compared to best practices.*

**Green**: Aligned with Best Practices

**Yellow**: Challenges Exist

**Red**: Significant Gaps

1. Assessment | Employee Climate and Culture – Methodology

A&M partnered with DPHHS to develop, distribute, and analyze the results of a climate and culture survey. The goal is to identify opportunities that facilities can invest in to improve employee satisfaction, engagement, and retention. **A summary of the complete survey results is available** [**here**](https://dphhs.mt.gov/assets/Facilities/MontanaEFDAssessmentClimateandCultureSurveyExecSummary.pdf)**.**

**Step 1: Design Survey**

* The survey is based on an evidence-based tool that has been scientifically developed and tested by distinguished research staff at Western Kentucky University.
* Input from DPHHS and facility leadership was incorporated into survey questions.
* The survey was published using the Qualtrics platform.

**Step 2: Distribute Survey**

* The survey opened on 5/13/22 and closed on 6/10/22 (close date was extended twice).
* Links and QR codes of the survey were distributed to employees via email blasts and posters in breakrooms. Paper forms were also available at facilities as requested.
* Employees provided feedback via smartphone, computer, and paper forms.

**Step 3: Analysis**

* Steps were taken to anonymize responses: demographic information separated from open-ended responses; open-ended responses summarized by themes; and not analyzing groups with less than 5 responses.
* Quantitative analysis was conducted using Python, and SPSS with various statistical methods.
* Qualitative analysis was conducted using python, manual review, and thematic content analysis.

**Key Takeaways**

1. Employees reported **dissatisfaction with their salaries** across all facilities, noting they were not competitive with similar jobs
2. Employees reported there were **limited professional development and training opportunities** at the facilities, and also noted dissatisfaction with opportunities for promotion.
3. Employees reported **high senses of accomplishment** across all facilities, noting that they sought this line of work due to their commitment to health care.
4. Assessment | Employee Climate and Culture – Results Summary

MCDC and SWMVH have the highest overall employee satisfaction levels. MMHNCC and MSH had the lowest overall employee satisfaction levels. Across all facilities, employees reported highest satisfaction with accomplishment and lowest satisfaction with salary. This is particularly the case for CFMVH where the median home cost is over $450,000.

**Methodology:** Employees responded to survey questions within each dimension using a 1 to 5 scale. A satisfaction level was created for each employee by averaging the scores for each survey question response. This represents each respondent’s satisfaction level regarding the corresponding dimension.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Dimension** | **Average Satisfaction Level** | | | | | | | |
| **Overall** | **MSH** | **MMHNCC** | **IBC** | **MCDC** | **CFMVH** | **SWMVH\*** | **EMVH\*** |
| **Accomplishment** | **3.7** | 3.5 | 3.4 | 3.6 | 4.1 | 4.0 | 4.1 | 3.8 |
| **Supervision** | **3.5** | 3.4 | 3.2 | 3.7 | 3.8 | 3.6 | 3.9 | 3.9 |
| **Workload** | **3.1** | 3.1 | 2.8 | 3.1 | 3.8 | 2.8 | 3.7 | 3.6 |
| **Recognition** | **3.1** | 2.7 | 2.6 | 2.9 | 3.5 | 3.6 | 3.8 | 3.5 |
| **Support** | **3.0** | 2.7 | 2.5 | 2.9 | 3.7 | 3.2 | 3.5 | 3.2 |
| **Development** | **2.9** | 2.7 | 2.8 | 2.8 | 3.1 | 3.1 | 3.2 | 3.3 |
| **Salary** | **2.5** | 2.7 | 2.4 | 2.6 | 2.8 | 1.9 | 3.3 | 3.0 |
| **Overall** | **3.1** | **3.0** | **2.8** | **3.1** | **3.6** | **3.2** | **3.6** | **3.5** |
| *Count* | *410* | *155* | *62* | *17* | *46* | *81* | *22* | *23* |

*Notes: \*Southwestern Montana Vets Home (SWMVH) and Eastern Montana Vets Home (EMVH) are run by contractors.*

1. Assessment | Expenses at State Facilities: Four Year Snapshot

In the last four years, total expenses across all state-run facilities has risen – in part due to an increase in non-labor expenses such as traveler nurses at MSH and IBC. This increase in expenses has been coupled with a decrease in revenue for FY22 – more detail on revenue is on the [next slide](#Assessment_RevenueatStateFacilities).

FY22 was the first year that non-labor expenses exceeded labor expenses at MSH and IBC

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Facility | Expense Type | FY19 | FY20 | FY21 | FY22 |
| **MSH** | Labor | $32,390,810 | $ 31,095,197 | $ 20,991,618 | $ 24,353,886 |
|  | Non-Labor | $16,905,215 | $ 16,089,796 | $ 20,161,391 | $ 37,115,008 |
|  | **Total** | **$49,296,025** | **$ 47,184,993** | **$ 41,153,009** | **$ 61,468,894** |
| **MMHNCC** | Labor | $7,285,758 | $ 8,283,679 | $ 6,784,532 | $ 7,735,836 |
|  | Non-Labor | $4,170,397 | $ 4,048,589 | $ 3,812,842 | $ 3,666,558 |
|  | **Total** | **$11,456,156** | **$ 12,332,268** | **$ 10,597,374** | **$ 11,402,394** |
| **MVH** | Labor | $8,496,990 | $ 8,909,159 | $ 6,462,684 | $ 8,330,112 |
|  | Non-Labor | $2,971,657 | $ 2,900,827 | $ 3,192,131 | $ 2,813,495 |
|  | **Total** | **$11,468,647** | **$ 11,809,985** | **$ 9,654,815** | **$ 11,143,607** |
| **IBC** | Labor | $5,023,614 | $ 3,729,758 | $ 3,351,444 | $ 2,403,021 |
|  | Non-Labor | $1,968,019 | $ 1,112,781 | $ 1,078,950 | $ 3,499,952 |
|  | **Total** | **$6,991,632** | **$ 4,842,539** | **$ 4,430,394** | **$ 5,902,973** |
| **MCDC** | Labor | $3,700,778 | $ 3,909,762 | $ 3,182,655 | $ 4,043,576 |
|  | Non-Labor | $1,304,630 | $ 1,294,883 | $ 1,307,663 | $937,996 |
|  | **Total** | **$5,005,408** | **$ 5,204,645** | **$ 4,490,318** | **$ 4,981,572** |
| **EMVH** | Labor | $ 71,938 | $69,664 | $93,071 | $58,960 |
|  | Non-Labor | $2,366,042 | $ 3,043,592 | $ 3,251,582 | $ 3,184,515 |
|  | **Total** | **$2,437,981** | **$ 3,113,255** | **$ 3,344,653** | **$ 3,243,475** |
| **SWMVH** | Labor | $ - | $63,610 | $101,269 | $79,479 |
|  | Non-Labor | $ - | $59,802 | $ 2,002,058 | $ 2,959,376 |
|  | **Total** | $ - | **$123,412** | **$ 2,103,327** | **$ 3,038,855** |
| **Grand Total** |  | **$86,655,848** | **$ 84,611,098** | **$ 75,773,890** | **$ 101,181,770** |

**Summary of Findings**

* Expenses have risen since FY19 across facilities, with expenses at MSH accounting for over 50 percent of total facilities spend
* Non-labor expenses include traveler / temporary contracted staff.

1. Assessment | Revenue at State Facilities: Three Year Snapshot

Revenue dropped for all facilities in FY22 – at MSH, this drop in revenue is largely explained by the CMS decertification in April 2022. With expenses, including traveler spend, on the rise, CMS recertification, renegotiating traveler staff contracts, and filling vacant FTE positions are critical pieces to improving the financial health of MSH.

CMS decertification in April 2022 impacted numbers May-July

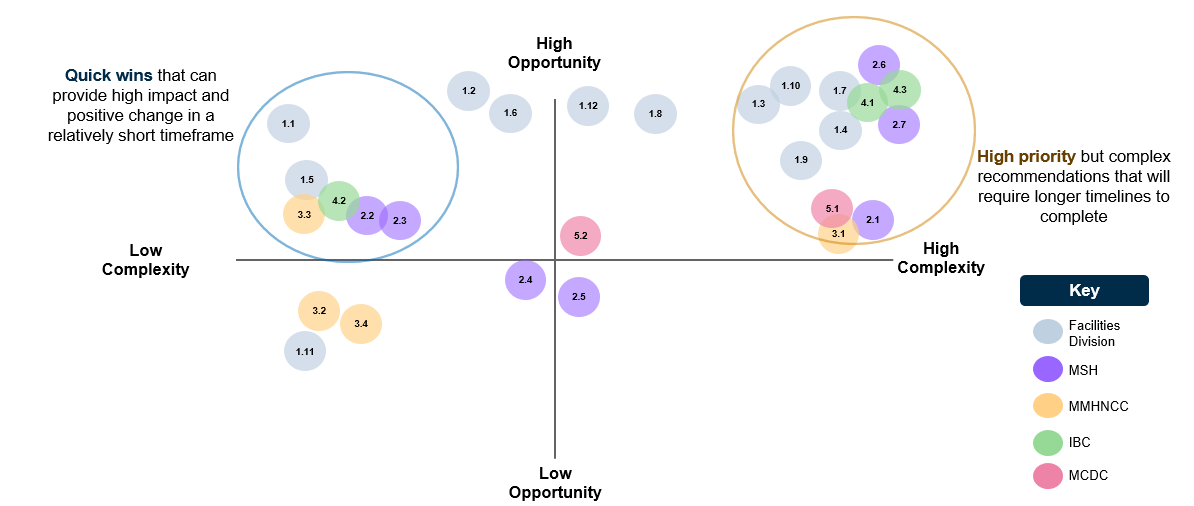
|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Facility | FY | Insurance | Medicaid | Medicaid Expansion | Medicare | Part D | Private | Grand Total |
| **MSH** | 2020 | $643,048 | $795,535 | $135,074 | $ 5,782,977 | $ - | $ 1,216,111 | **$8,572,744** |
|  | 2021 | $698,181 | $ 1,374,274 | $175,829 | $ 6,745,737 | $ - | $ 1,000,526 | **$9,994,548** |
|  | 2022 | $ 1,260,733 | $724,474 | $66,745 | $ 5,446,059 | $ - | $ 1,374,494 | **$8,872,505** |
| **MMHNCC** | 2020 | $23,691 | $ 2,753,788 | $ - | $17,976 | $444,449 | $769,700 | **$4,009,603** |
|  | 2021 | $625,063 | $ 4,288,825 | $20,315 | $26,464 | $316,377 | $746,194 | **$6,023,239** |
|  | 2022 | $524,013 | $ 3,634,076 | $ - | $35,782 | $275,195 | $702,938 | **$5,172,003** |
| **MVH** | 2020 | $23,763 | $ 1,247,137 | $ - | $224,548 | $65,790 | $ 3,607,726 | **$5,168,964** |
|  | 2021 | $13,341 | $ 1,605,042 | $ - | $235,406 | $12,880 | $ 3,081,337 | **$4,948,006** |
|  | 2022 | $30,396 | $ 1,093,818 | $ - | $375,745 | $2,360 | $ 2,487,275 | **$3,989,594** |
| **MCDC** | 2020 | $22,618 | $369,768 | $ 1,778,936 | $2,803 | $ - | $(2,310) | **$2,171,817** |
|  | 2021 | $23,684 | $309,509 | $ 1,411,483 | $1,042 | $ - | $8,521 | **$1,754,239** |
|  | 2022 | $71,575 | $341,425 | $ 1,466,764 | $2,396 | $ - | $9,538 | **$1,891,698** |
| **IBC** | 2020 | $ - | $ 3,520,415 | $ - | $ - | $ - | $90,153 | **$3,610,568** |
|  | 2021 | $ - | $ - | $ - | $ - | $ - | $87,229 | **$ 87,229** |
|  | 2022 | $ - | $ - | $ - | $ - | $ - | $74,497 | **$ 74,497** |

**Revenue as a % of Expenses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility** | **FY20** | **FY21** | **FY22** |
| MSH | 18% | 24% | 11% |
| MMHNCC | 33% | 57% | 38% |
| MVH | 44% | 52% | 31% |
| MCDC | 42% | 39% | 29% |
| IBC | 75% | 2% | 1% |

1. Recommendations for Improvement
2. Recommendations | Summary of Prioritization

Our recommendations are prioritized based on the opportunity for impact they present and their level of complexity. Level of impact was measured by how significantly implementation of the recommendation would improve quality and delivery of care. Level of complexity was defined by the cost of implementation, length of implementation, stakeholder engagement needed, and obstacles to implementation (including public opinion).



1. 1.1 Healthcare Facilities Division | Stand Up Transformation Office

**RECOMMENDATIONS**

* Establish Transformation Management Office, which is a central project team that will oversee implementation of A&M’s recommendations.
* Establish project governance and steering committee to provide oversight and accountability for results.
* Manage stakeholder engagement and input, including with state agencies, employees and bargaining unions, advocacy groups, provider associations, legislative committees, and patient families and guardians.
* Develop comprehensive communication and change management strategy including education for leaders to introduce / compare new solution and roadmap.

**Benefits:** Develop an organized, unified approach to the implementation of recommendations without duplicating efforts across projects.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Accountability & Transparency

One Time Costs: $1.7MM

Recurring Costs: None

**CONSIDERATIONS**

Risks: Lack of sponsorship; lack of funding to implement recommendations

Dependencies: N/A

Resources: DPHHS leadership, temporary contract staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-month Duration Timeline** |
| 1. | Identify team | 1st Month |
| 2. | Stand up governance and steering committees | 1st Month |
| 3. | Develop communications and change management plans | 2nd to 3rd Month |
| 4. | Execute changes and regularly communicate with key stakeholder groups | 2nd to 11th Month |
| 5. | Develop plan to transition to operations | 10th to 12th Month |

1. 1.2 Healthcare Facilities Division | Hire Clinical and Operational Leadership

**RECOMMENDATIONS**

* Create new clinical and operational leadership positions, including: Deputy Chief Healthcare Officer, Chief Medical Officer, Chief Nursing Officer, Chief Clinical Officer, and two Quality Managers. Administrative support roles should also be created to support the leadership team.
* Conduct cost-benefit analysis to determine whether to hire as contracted services or as full-time employees.
* Implement matrixed reporting relationships so that physicians, nursing, operations, treatment, and quality programs, across all facilities, are supervised by new divisional leadership positions.
* Set roles and responsibilities and support changes in roles.

**Benefits:** New leadership will ensure a higher level of accountability, oversight, and transparency at the facilities, thus improving the quality of care provided.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Accountability, Transparency, & Improved Delivery of Care

One Time Costs: None

Recurring Costs: $1.5MM

**CONSIDERATIONS**

Risks: Difficulties attracting talent given pay

Dependencies: Approval of funding

Resources: State Procurement and/or Human Resources

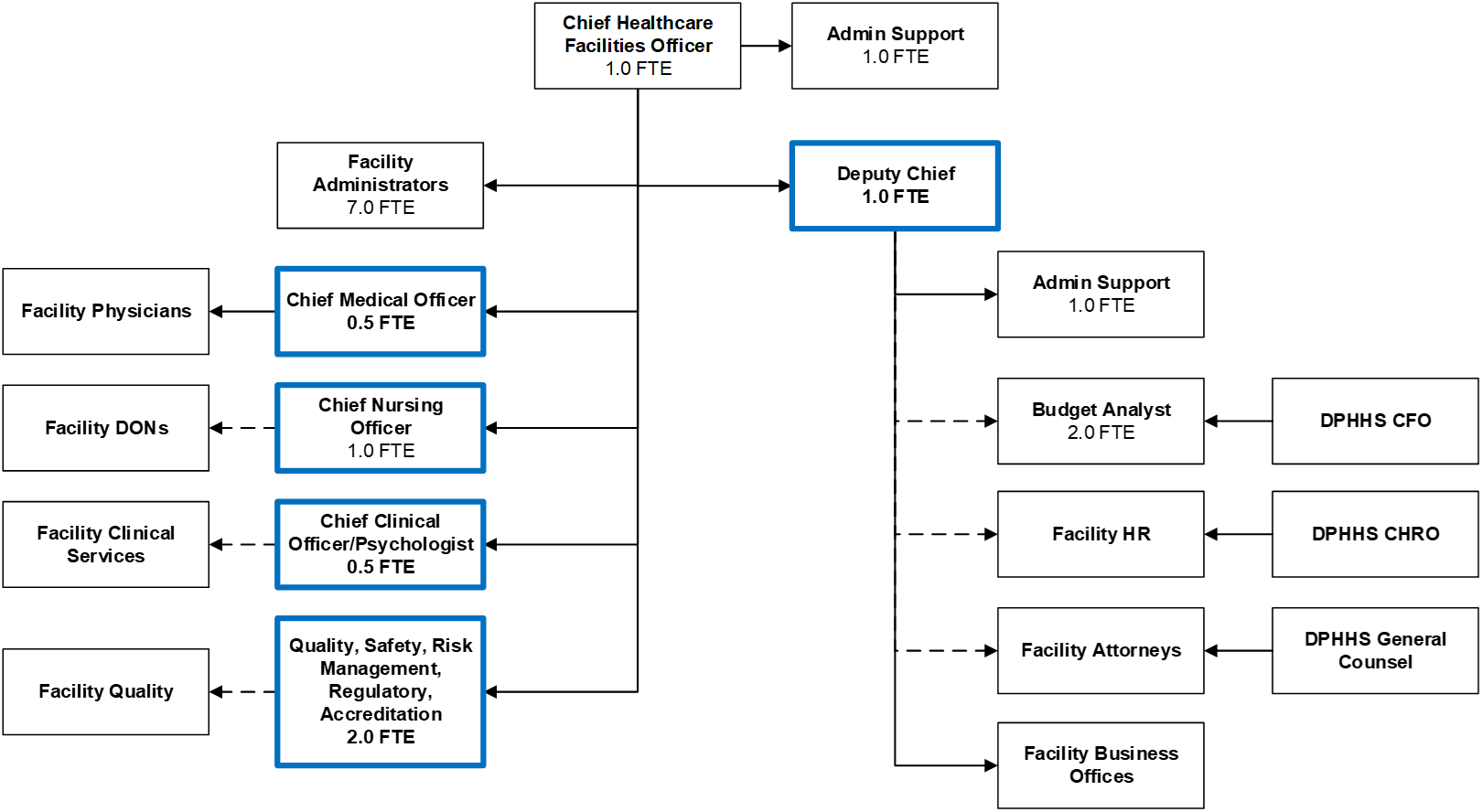
**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-month Duration Timeline** |
| 1. | Conduct cost-benefit analysis and determine whether to hire positions as contractors or full-time employees | 1st Month |
| 2. | Develop job descriptions and post to the State’s job board | 1st and 2nd Month |
| 3. | Conduct hiring and recruitment processes, or competitive procurement | 2nd to 4th Month |
| 4. | Realign facility reporting relationships to new clinical leadership positions as applicable | 2nd to 11th Month |
| 5. | Monitor performance | 10th to 12th Month |

1. 1.2 Healthcare Facilities Division | Hire Clinical and Operational Leadership

Below are the recommended clinical leadership roles & responsibilities for the Healthcare Facilities Division.

|  |  |  |
| --- | --- | --- |
| **Position** | **Roles and Responsibilities** | **Est. Annual Cost** |
| Chief Medical Officer  0.5 FTE | * Oversees development, implementation, maintenance and enhancement of all clinical and medical services and programs, medical policies and procedures, and quality assurance programs and activities * Provides leadership and direction for all for providers * Supports medical staff peer review, credentialing, privileging, reviews of incidents, management of disciplinary actions | $350,000 |
| Chief Nursing Officer  1.0 FTE | * Provides leadership to all nursing teams at the facilities * Ensures level of care required by current medical and nursing standards | $136,000 |
| Chief Clinical Officer  0.5 FTE | * Provides leadership to all treatment teams at the facilities * Ensures treatment meets quality and safety | $63,000 |
| Quality Program Managers  2.0 FTE | * Develops and oversees program quality metrics * Supports risk management activities, including tasks related to regulatory requirements and accreditation | $215,000 |
| Deputy Chief  1.0 FTE | * Oversees operations and back-office support improvements across all facilities * Develops financial governance processes and * Ensures compliance with federal and state laws | $136,000 |



**Recommended Future State Division Structure**

1. Healthcare Facilities Division | Optimize Clinical Services

**RECOMMENDATIONS**

* Develop minimum clinical staffing levels by facility, specialty, and function.
* Implement telemedicine by facility, specialty, and function. Telemedicine should include usage of tele-sitters to reduce costs of 1:1 supervision.
* Restructure clinical services across facilities, mix of in-person and remote.
* Develop bylaws as practice guidelines for psychotropic medication use.
* Build governance processes for: peer review, ongoing and focused professional practice Evaluation, credentialing, and privileging.
* Implement Medical Staff function to oversee governance processes.

**Benefits**: Improved patient outcomes due to adequate staffing levels with high quality clinical staff, increased oversight, and governance processes.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $250K

Recurring Costs: $750K

**CONSIDERATIONS**

Risks: Difficulties attracting talent given pay

Dependencies: Approval of funding

Resources: State Procurement and/or Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | 12-months Duration Timeline |
| 1. | Conduct staffing analysis for each of the facilities, including RECOMMENDATIONS | 1st and 2nd Month |
| 2. | Implement staffing changes and restructuring | 2nd to 9th Month |
| 3. | Build governance processes | 8th to 10th Month |

1. Healthcare Facilities Division | Implement an Electronic Health Records System

**RECOMMENDATIONS**

* Assess feasibility of EHRs options and conduct competitive procurement processes.
* Develop change management plan, including training plan, for implementation at facilities.
* Build implementation roadmap for facility rollout.
* Deploy EHRs at facilities

**BENEFITS**: Higher quality and more efficient delivery of care, enable an integrated billing module, improve data quality, and an ability to use data to improve patient outcomes.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Delivery of Care

One Time Costs: $20MM

Recurring Costs: $2.2MM

**CONSIDERATIONS**

Risks: Difficulties with implementation due to challenges with IT infrastructure at facilities

Dependencies: Approval of funding

Resources: State Procurement and/or IT

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Feasibility assessment | 1st and 2nd Month |
| 2. | Competitive procurement processes | 3rd to 5th Month |
| 3. | Deploy EHRs at facilities | 5th to 28th Month |

1. Healthcare Facilities Division | Implement Competency-Based Job Descriptions

**RECOMMENDATIONS**

* Update job descriptions so that they include the expected level of performance (knowledge, skills, abilities, and judgment) for clinical roles.
* Require new employees to demonstrate their competency prior to starting their first shift, and require existing employees to re-demonstrate their competency on an annual basis. Competency should be routinely measured and documented.
* Provide additional education and training to employees so that they can become competent in their job.
* Update facility policies and procedures as required to support competency-based job descriptions.

**BENEFITS**: Improved patient safety and outcomes due to highly competent employees vetted through defined job competencies.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Patient Safety and Outcomes

One Time Costs: $350K

Recurring Costs: None

**CONSIDERATIONS**

Risks: Difficulties attracting talent given pay

Dependencies: Approval of funding

Resources: State Procurement and/or Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Review all job descriptions for care delivery across entire system, e.g., CNAs, RNs, etc. | 1st Month |
| 2. | Convert job descriptions to competency-based job descriptions, e.g., demonstrate competency in basic life support, individualized care plans, patient transfers | 1st and 2nd Month |
| 3. | Revise facility policies and procedures | 2nd Month |
| 4. | Support HR process to move employees to updated competency-based job descriptions, socialization with unions | 3rd and 4th Month |
| 5. | Facilitate job skills day via train-the-trainer model | 3rd and 4th Month |

1. Healthcare Facilities Division | Improve Training and Learning Management

**RECOMMENDATIONS**

* Establish a governance system to oversee training programs and implement a learning management system to improve training compliance, career tracking, etc.

**Benefits**: Higher staff retention due to professional development opportunities, as well as increased staff performance.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: Medium

**ESTIMATED IMPACT**

Benefits: Better Staff Performance and Increased Staff Retention

One Time Costs: $1MM

Recurring Costs: $500K

**CONSIDERATIONS**

Risks: Difficulties with implementation due to challenges with IT infrastructure at facilities

Dependencies: Approval of funding

Resources: State Procurement and/or IT

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Conduct competitive procurement process | 1st to 3rd Month |
| 2. | Develop roadmap for implementation | 1st to 3rd Month |
| 3. | Deploy LMS at facilities | 4th to 9th Month |
| 4. | Establish governance structure for training and learning management | 8th to 11th Month |

1. Healthcare Facilities Division | Conduct Hiring Blitz

**RECOMMENDATIONS**

* Update recruitment strategies and conduct a hiring blitz for Registered Nurses, Certified Nursing Assistants, Psychiatric Technicians, and Direct Support Professional positions.
* Investigate options for increasing the pool of applicants, including: hiring and referral bonuses; a career pipeline for high school and college students; apprenticeship programs; or teaching hospital designations.
* Contract with recruitment firms to assist with hiring of clinical staff.

**Benefits**: Improved patient outcomes due to lower vacancies at facilities, adequate staffing levels, and increased number of nurses and direct service professionals.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $512K for Bonuses and $250K for Recruiters

Recurring Costs: None

**CONSIDERATIONS**

Risks: Difficulties attracting talent given pay

Dependencies: Approval of funding

Resources: State Procurement and/or Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Assess priority positions for hiring across facilities | 1st Month |
| 2. | Develop recruitment and marketing plans for each facility | 1st and 2nd Month |
| 3. | Identify high-impact recruitment advertising opportunities | 1st Month |
| 4. | Work with key stakeholders, including external recruiters, facilities HR teams, and internal DPHHS HR team, to develop and implement hiring blitz | 2nd to 12th Month |
| 5. | Assess feasibility of additional hiring and pipeline opportunities | 3rd and 4th Month |

1. Healthcare Facilities Division | Conduct Hiring Blitz

As part of a hiring blitz, the Healthcare Facilities Division should investigate the feasibility of providing hiring and referral bonuses. Below is a recommended structure for these bonuses along with a conservative cost estimate model.

**Hiring Bonuses:**

Provided to hires in high-priority vacancies and positions (RNs, CNAs, DSPs, and Psych Techs) **two months** into their position.

**Recommended amount:** $1,500 one-time bonus

**Est. cost: $426,000**

* 258 priority vacancies in August 2022 (see table on right)
* $1,500 for each position
* 10% buffer + rounded up

**Referral bonuses:**

Provided to any employee under DPHHS who refers a candidate that is successfully hired to a high-priority vacancy so long as the new hire remains in the position for at least **two months.**

**Recommended amount:** $1,000 one-time bonus

**Est. cost: $86,000**

* Assume 30% of hires to 258 vacancies are successful referrals
* $1,000 for each referral
* 10% buffer + rounded up

**Retention bonuses:**

The feasibility of retention bonuses should be assessed given potential constraints with union CBAs and performance evaluation criteria at facilities (see recommendation [1.12](#Recommendation1_12))

**Recommended amount:** $500 for employees who remain for 1 year in their role, assuming high performance

**Est. cost:** TBD, heavily relies on assumptions

**Top 5 Vacant Positions across Facilities: August 2022**

|  |  |  |
| --- | --- | --- |
| **Position** | **# of Vacancies** | **% of Total Vacancies** |
| Psychiatric Technician | 111 | 31.1% |
| Registered Nurse (RN) | 47 | 13.2% |
| Certified Nurse Aide (CNA) | 46 | 12.9% |
| Direct Support Professional | 32 | 8.9% |
| Psychiatric Technician FMHT | 22 | 6.2% |

**Est. Total for Hiring and Referral Bonuses: $512,000**

1. Healthcare Facilities Division | Consolidate Temporary Staffing Contracts

**RECOMMENDATIONS**

* Consolidate temporary contracted services spend and recompete staffing contracts to reduce costs and complexity of administration.

**Benefits**: Facilities cost savings due to consolidated spend and reduced rates for temporary healthcare staffing.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: Medium

**ESTIMATED IMPACT**

Benefits: Increased facilities cost savings

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Complications surrounding prolonged and contentious negotiations

Dependencies: Approval of funding

Resources: State Procurement and/or Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Meet with key stakeholders to discuss goals for staffing contract negotiations | 1st Month |
| 2. | Conduct staffing contract negotiations and recompetes | 1st to 3rd Month |

1. Healthcare Facilities Division | Establish Financial Accountability and Governance

**RECOMMENDATIONS**

* Implement active budget, contract, and revenue management processes to control costs.
* Realign reporting structure so that finance and accounting staff report to the agency’s CFO.
* Re-baseline facility budgets, especially MSH, so that budgets reflect the actual operational costs.
* Create goals for the next five fiscal years to improve the financial stability of the facilities.

**Benefits:** Improved financial stability at facilities, risk management, accountability, governance, and transparency.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved financial stability at facilities

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Upfront costs to establish governance along with RECOMMENDATIONS to get facilities on track may be high

Dependencies: Success of other fiscal recommendations, including 1.8

Resources: Facilities leaders, Budget team

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Develop budget policies & procedures for each of the facilities | 1st to 3rd Month |
| 2. | Establish governance structure for facility financial controls, including – budget review processes, reporting cadence, and oversight | 1st and 2nd Month |
| 3. | Set goals for the next five fiscal years for each of the facilities to move towards financial stability | 2nd and 3rd Month |

1. Healthcare Facilities Division | Staff to Acuity and Need

**RECOMMENDATIONS**

* Update staffing plans so that facilities are staffed to acuity, census, and need.
* Use benchmarks to inform staffing levels and comparison
* Create staffing model to adjust staffing as demand and needs change in the future.

**Benefits:** Improved patient outcomes due to adequate staffing levels, where staff can most efficiently provide care.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Difficulties attracting talent given pay

Dependencies: Approval of funding, Union CBAs

Resources: Facilities leader

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Conduct staffing analysis for each of the facilities, including recommendations on staffing need | 1st and 2nd Month |
| 2. | Implement staffing changes and restructuring | 1st to 7th Month |
| 3. | Develop staffing model to be used if future adjustments are needed to staffing levels | 2nd to 4th Month |

1. Healthcare Facilities Division | Improve Therapeutic Environment

**RECOMMENDATIONS**

* Purchase furnishings and other physical assets for all state-run healthcare facilities to improve therapeutic environment and ensure appropriate infection control efforts are occurring.

**Benefits:** Improved patient outcomes due to a more comfortable, safe, and welcoming therapeutic environment.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Low

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $500K

Recurring Costs: None

**CONSIDERATIONS**

Risks: Supply chain and budget issues can impact purchasing

Dependencies: Approval of funding

Resources: Facilities leaders, State Procurement

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | Activities | **12-months Duration Timeline** |
| 1. | Assess facility needs regarding physical assets, infrastructure, and furnishings | 1st Month |
| 2. | Conduct procurement processes to order furnishings | 1st and 2nd Month |

1. Healthcare Facilities Division | Increase Wages

**RECOMMENDATIONS**

* Increase wages to market rates to help recruit and retain employees.
* Work heavily with stakeholders across Montana government to gain approval for and implement wage increases.

**Benefits**: Improved patient outcomes due to lower staff turnover, higher employee satisfaction, and higher retention rates.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: High

Complexity: Medium

**ESTIMATED IMPACT**

Benefits: Higher Employee Satisfaction and Retention

One Time Costs: $9.4M increase in FY24 labor costs

Recurring Costs: $2 – 3M increase for cost-of-living adjustments annually (COLA)

**CONSIDERATIONS**

Risks: Need for consensus across various state government entities

Dependencies: Approval of funding, union CBAs, agreement from key stakeholders

Resources: State Procurement and/or Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Work with key stakeholders, including Human Resources, the legislature, unions, and others to determine feasible increases to wages and bonuses | 1st to 9th Month |
| 2. | Develop pay scales for each of the positions | 8th and 9th Month |
| 3. | Roll out wage increases and bonuses | 10th to 12th Month |

1. MSH | Close Spratt

**RECOMMENDATIONS**

* Make interim life safety improvements at unit to address existing deficiencies.
* Close the geriatric psychiatric unit at MSH (“Spratt Unit”).
* Discharge current patients to Montana Mental Health Nursing Care Center and community providers.
* Conduct assessment to determine whether to repurpose these beds for hospital use.

**Benefits**: Improved patient outcomes due to better placement based on person-centered planning and needs.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $2.5MM

Recurring Costs: None

**CONSIDERATIONS**

Risks: Logistical barriers to transitioning patients out of Spratt and closing the facility

Dependencies: Approval of funding

Resources: MSH CEO, social workers

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Stand up a transition team at the facility to manage the transition process | 1st Month |
| 2. | Assess all patients at Spratt, including an assessment of their acuity, programmatic and person-centered needs | 1st and 2nd Month |
| 3. | Communicate with families to incorporate their input into transition planning | 1st and 2nd Month |
| 4. | Locate available transition facilities and develop comprehensive transition plans | 1st to 3rd Month |
| 5. | Transition patients and close down Spratt | 4th to 9th Month |

1. MSH | Implement Case Management

**RECOMMENDATIONS**

* Implement case management model to prepare patients for discharge on admission and based on their projected length of stay and acuity.
* Assess alternatives for case management models and select most appropriate model for facility.
* Train staff on case management policies and procedures.

**Benefits**: Better patient outcomes due to more efficient, person-centered discharge policies that are matched to need and acuity. Recertification will allow the state to receive approximately $8M per year in federal dollars to the general fund.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $300K

Recurring Costs: None

**CONSIDERATIONS**

Risks: Delays in other improvement initiatives at MSH pushing out implementation

Dependencies: Consensus on appropriate case management model to use

Resources: Facilities leaders and clinical staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Provide training to facilities staff on person-centered planning and case management model best practices | 1st to 4th Month |
| 2. | Create case management policies & procedures | 1st to 4th Month |

1. MSH | Restructure Patient Placement

**RECOMMENDATIONS**

* Restructure patient placement by acuity and their individual needs so that highest levels of care are provided in A and Galen.
* Develop admission and discharge criteria. Staff to acuity, census, and need within the restructured units.
* Reduce restrictions on units with lower acuity.
* Structure step down units through B, D, E, Spratt, and group homes to improve care delivery.

**Benefits**: Improved patient outcomes due to better milieu and placement based on person- centered planning and needs.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Logistical barriers to restructuring patient placements

Dependencies: N/A

Resources: Facilities leaders and clinical staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Assess all patients, including assessment of their acuity, programmatic, and person-centered needs | 1st and 2nd Month |
| 2. | Identify appropriate patient placement settings | 2nd and 3rd Month |
| 3. | Develop comprehensive transition plans | 2nd and 3rd Month |
| 4. | Transition patients | 3rd and 4th Month |

1. MSH | Refine Delivery of Active Treatment

**RECOMMENDATIONS**

* Develop appropriate policy for delivery of active treatment.
* Restart therapeutic programming impacted by the pandemic.
* Identify activities for patients to participate during the day and night as appropriate to their need – including activities within the community.

**Benefits**: Improved patient outcomes as a result of person-centered treatment and planning, as well as an increased focus on community activities that better prepare patients for community integration.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: Medium

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $300K

Recurring Costs: None

**CONSIDERATIONS**

Risks: Quality control and treatment oversight

Dependencies: Chief Medical Officer position hire, implementation of medical staff function

Resources: Facilities leaders and clinical staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Assess all patients, including assessment of their acuity, programmatic, and person-centered needs | 1st and 2nd Month |
| 2. | Develop active treatment policies & procedures and identify appropriate activities for patients, including community activities | 1st and 2nd Month |
| 3. | Train clinical staff on new policies for delivery of active treatment | 2nd and 3rd Month |
| 4. | Implement active treatment delivery adjustments | 3rd to 6th Month |

1. MSH | Change Forensic Statutory Criteria for Admission

**RECOMMENDATIONS**

* Change forensic statutory criteria at MCA 46-14 for admission and discharge to mirror civil statutory criteria at MCA 53-21 so that MSH is not required to accept patients that do not meet the new criteria.

**Benefits**: Better delivery of care at MSH so that the facility can treat patients that are best suited to the facility, ensuring patients are placed in environments most conducive to their needs.

**PRIORITY**

*Opportunity*

*Complexity*

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**-**

Opportunity: Medium

Complexity: Medium

**ESTIMATED IMPACT**

Benefits: Increase MSH efficiency in care delivery

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Legislative barriers and need to build consensus

Dependencies: Legislative approval

Resources: Legal team, legislators

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Conduct legislative analysis for changes needed | 1st Month |
| 2. | Work and negotiate with key stakeholders to make legislative rule changes | 1st to 6th Month |

1. MSH | Achieve CMS Compliance and Seek Recertification

**RECOMMENDATIONS**

* Seek CMS re-certification over the next 2 years and then CARF or Joint Commission accreditation to improve quality oversight.
* Develop corrective action plans to respond to CMS survey findings.
* Support MSH with ongoing continued compliance efforts and risk management.

**Benefits**: Improved patient outcomes and more efficient management of the facility as a result of measures taken to comply with CMS regulations and seek re-certification. Increases the financial sustainability of MSH by bringing back federal funding associated with CMS certification.

**PRIORITY**

*Opportunity*

*Complexity*

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**+**

**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes and Facilities Management

One Time Costs: $10MM

Recurring Costs: None

**CONSIDERATIONS**

Risks: Failure due to lack of preparedness, extending the timeline significantly

Dependencies: N/A

Resources: State Procurement and/or Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Perform a high-level assessment to determine the required time, resources, and financial support that will be needed to reattain CMS certification | 1st Month |
| 2. | Conduct a high-level assessment to verify that the hospital complies, or does not comply, with the CoPs and the State requirements for the mandatory standards along with the degree, or severity, of any findings and produce a gap analysis | 1st and 2nd Month |
| 3. | Work with the facility to develop a corrective action plan | 1st and 2nd Month |
| 4. | Facilitate application process to CMS for recertification | 2nd to 6th Month |
| 5. | Develop corrective action plans as required to respond to CMS survey findings | 3rd to 12th+Month (*Approximately 24 months)* |

1. MSH | Right-size Capacity

**RECOMMENDATIONS**

* Improve Montana’s long-term delivery of care by building two new, regional, private behavioral healthcare settings that complement and support MSH and the other state-run facilities in large population areas.
* Collaborate with relevant government stakeholders to improve mental health and restoration of competency services within jails, providing access to these services quicker and at a lower cost than placement at MSH, which currently has a long waitlist.

**Benefits**: Increased access to care in underserved, high-population region and improved delivery of care in critical settings. Address the shortage of beds across the state.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

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**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Increased access to behavioral health care

One Time Costs: $84M

Recurring Costs: $37M in operating costs

**CONSIDERATIONS**

Risks: Long-term process with several key junctures that may cause delays

Dependencies: Approval of funding

Resources: State Procurement, Facilities team, Architecture & Engineering (A&E) team

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Conduct feasibility assessment to determine the most effective location for the new facilities | 1st Month |
| 2. | Conduct competitive procurement activities for any needed contracting services | 1st and 2nd Month |
| 3. | Roll out plan to construct facilities | 2nd to 12th Month |

1. MMHNCC | Build Out Secured Memory Unit

**RECOMMENDATIONS**

* Build out infirmary, including purchasing of beds and furniture, as secured memory unit to receive patients from Spratt.
* Obtain updated long term care license to account for increase in beds, including CMS licensure.
* Increase capacity at MMHNCC to support more complex cases.

**Benefits**: Improve patient outcomes through more appropriate placement of patients and person-centered planning practices.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $500K

Recurring Costs: TBD

**CONSIDERATIONS**

Risks: Logistical barriers to transitioning patients out of Spratt and closing the facility

Dependencies: Approval of funding

Resources: State Procurement, Facilities leaders

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Stand up a transition team at the facility to manage the transition process | 1st Month |
| 2. | Prepare MMHNCC to receive patients from Spratt, including staff and facility changes needed | 1st and 2nd Month |
| 3. | Transition patients based on the comprehensive transition plans | 3rd and 4th Month |

1. MMHNCC | Implement Person-Centered Standards of Practice

**RECOMMENDATIONS**

* Update standards of practice and ordering protocols to meet each patient’s programmatic and person-centered needs.
* Train staff in person-centered thinking.
* Develop person-centered plans for current patients and policies for future person-centered plan development.

**Benefits**: Improved patient outcomes through a focus on person-centered vs. programmatic planning, increasing stability of the facility and policies to ensure appropriate patient placement.

**PRIORITY**

*Opportunity*

*Complexity*

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**-**

Opportunity: Low

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: $200K

Recurring Costs: None

**CONSIDERATIONS**

Risks: N/A

Dependencies: Appropriate staffing levels and staff skill mix

Resources: Facilities leaders and clinical staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Assess patients using person-centered thinking methods | 1st Month |
| 2. | Provide training to facilities staff on person-centered planning and best practices | 1st and 2nd Month |
| 3. | Create person-centered planning policies & procedures | 2nd Month |

1. MMHNCC | Improve End-Of-Life Care Policies

**RECOMMENDATIONS**

* Contract with licensed hospice organization and develop end-of-life care policies aligned to modern practices.
* Assess patient end-of-life care needs and update care plans to align with best practices and findings.
* Develop policies & procedures aligned with best practices.
* Train staff in appropriate end-of-life care practices.

**Benefits**: Improved patient outcomes through updating and modernizing care practices to emphasize compassionate, person-centered end-of-life care.

**PRIORITY**

*Opportunity*

*Complexity*

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**-**

Opportunity: Medium

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: None

Recurring Costs: $150K

**CONSIDERATIONS**

Risks: N/A

Dependencies: Timeliness of contracting processes

Resources: Facilities leaders and clinical staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Conduct competitive procurement process to contract with a licensed hospice organization, as needed | 1st to 3rd Month |
| 2. | Assess patients end-of-life care needs using person-centered planning methods | 4th Month |
| 3. | Provide training to facilities staff on person-centered planning and best practices | 4th and 5th Month |
| 4. | Refine and modernize end-of-life care policies & procedures | 4th and 5th Month |

1. MMHNCC | Restructure Staffing Hierarchy

**RECOMMENDATIONS**

* Restructure operations to improve communications and patient outcomes.
* Assess existing staff hierarchy for areas of opportunity and efficiency in organization.
* Seek staff input in restructuring.

**Benefits**: Improved patient outcomes through updating and modernizing care practices to emphasize compassionate, person-centered end-of-life care.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Low

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Staff Outcomes and Facility Management

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Employee turnover if unhappy with changes

Dependencies: Union CBAs, staffing levels and skills mix

Resources: Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Conduct staffing assessment, including reviewing exit interviews and staff job descriptions | 1st to 3rd Month |
| 2. | Develop recommendations for staff restructuring and work with stakeholders to refine | 4th Month |
| 3. | Implement staff restructuring | 4th and 5th Month |

1. MMHNCC | Improve Admissions and Discharge Process

**RECOMMENDATIONS**

* Develop person-centered admissions and discharge policies to prepare patients for discharge on admission and based on their projected length of stay and acuity.
* Train staff on procedures.

**Benefits**: Better patient outcomes due to more efficient, person-centered discharge policies that are matched to need and acuity.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Improved Patient Outcomes

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Delays in other improvement initiatives at MSH pushing out implementation

Dependencies: Consensus on appropriate model to use

Resources: Facilities leaders and clinical staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Provide training to facilities staff on person-centered planning and best practices | 1st to 4th Month |
| 2. | Create policies & procedures | 1st to 4th Month |

1. IBC | Improve Quality of Care

**RECOMMENDATIONS**

* Bring in an experienced interim facility administrator to generate immediate improvement, aligning practices with federal ICF regulations. Consider hiring an experience private vendor to manage the facility, leading to rapid stabilization and improvement.
* Improve quality of care with more active treatment, modernized treatment plans, enhanced treatment areas, and improve integration within the local community.
* Update policies and procedures based on National Association for the Dually Diagnosed (NADD) standards.

**Benefits**: Improved client outcomes due to improvement of treatment practices and updated policies and procedures rooted in best practices and nationally-recognized, data-driven policy.

**PRIORITY**

*Opportunity*

*Complexity*

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**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Client Outcomes

One Time Costs: $500K

Recurring Costs: None

*Notes: 1. Recurring costs offset by funds typically directed to state operation of IBC.*

**CONSIDERATIONS**

Risks: Loss of existing staff not interested in making the transition

Dependencies: Locating an experienced contractor/organization

Resources: Facilities leaders and clinical staff, some investment in facility

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Bring in an interim facility administrator | 1st to 3rd Month |
| 2. | Assess all clients, including an assessment of their acuity, programmatic, and person-centered needs | 2nd Month |
| 3. | Develop active treatment policies & procedures, update treatment plans, and introduce new tools to monitor program integrity | 1st and 2nd Month |
| 4. | Train staff on new policies for delivery of active treatment | 2nd Month |
| 5. | Implement active treatment delivery adjustments | 3rd and 4th Month |
| 6. | Update remaining policies & procedures based on best practices from NADD | 3rd and 4th Month |
| 7. | Consider a contract to bring in an organization experienced with management and successful operation of a short-term, intensive treatment facility, licensed as an ICF/IID | 4th to 12th Month |

1. IBC | Implement Person-Centered Discharge Processes

**RECOMMENDATIONS**

* Update the discharge planning process to include person-centered practices (e.g., Charting the LifeCourse) and active transition planning with the provider community.

**Benefits**: Improved client outcomes through a focus on person-centered vs. programmatic planning, increasing stability of the facility and policies to ensure appropriate patient placement.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: Low

**ESTIMATED IMPACT**

Benefits: Increase Community Integration

One Time Costs: $100K

Recurring Costs: None

**CONSIDERATIONS**

Risks: N/A

Dependencies: Appropriate staffing levels and staff skill mix

Resources: Facilities leaders and clinical staff

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Assess clients using Charting the LifeCourse tools (e.g., Vision Tool, Life Trajectory) | 1st Month |
| 2. | Update individual plans to include results from person-centered planning assessment built around Charting the LifeCourse | 1st Month |
| 3. | Provide training to facilities staff on person-centered planning and best practices | 1st and 2nd Month |
| 4. | Create person-centered planning policies & procedures | 2nd Month |

1. IBC | Transition to New, Private Facility

**RECOMMENDATIONS**

Implement an intensive community alternative to IBC over next 2-3 years,  
allowing for replacement of the current facility in Boulder with a new facility located within a proximate population center.

* Create a small, effective, alternate and more home-like care setting for individuals with I/DD that need a higher level of support.

**Benefits**: Moving from a publicly-run ICF/DD to a privately-managed ICF/IID will result in increased accountability, increased quality of services being delivered, decreased cost, and the ability to serve more individuals with complex needs.

**PRIORITY**

*Opportunity*

*Complexity*

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**-**

Opportunity: High

Complexity: High

**ESTIMATED IMPACT**

Benefits: Improved Client Outcomes and Facility Management, Obtain Federal Match

One Time Costs: $10MM1

Recurring Costs: $7.5MM (limited net impact to GF if IBC sunsets)

*Notes: 1. Cost dependent on use of an existing facility vs. a new facility*

**CONSIDERATIONS**

Risks: Long-term process with several key junctures that may cause delays

Dependencies: Approval of funding, consensus building with key stakeholders

Resources: State Procurement, Facilities team, Architecture & Engineering (A&E) team

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Conduct feasibility assessment to determine the most effective location for the new facilities | 1st to 3rd Month |
| 2. | Conduct competitive procurement activities for any needed contracting services | 2nd to 5th Month |
| 3. | Plan, design, and build alternative location | 5th to 12th+Month (*Over 18 – 30 months)* |

**Additional, longer-term activities:**

* Assess clients and develop comprehensive transition plans
* Transition clients to new facility
* Operate and certify new location as an ICF/IID

1. MCDC | Reevaluate Number of Beds

**RECOMMENDATIONS**

* Reevaluate need for acute beds within the substance use disorder continuum of care.
* Assess demand across the state network, including by location, to right-size beds at MCDC.

**Benefits**: More cost-efficient facility management and reduced costs to the state by right-sizing the number of beds based on the demand across the state-wide network.

**PRIORITY**

*Opportunity*

*Complexity*

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**+**

**-**

Opportunity: Medium

Complexity: High

**ESTIMATED IMPACT**

Benefits: Reduce Cost to State

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: Need for consensus among stakeholders

Dependencies: Approval of funding

Resources: State Procurement and/or Human Resources

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Conduct feasibility assessment to determine best option for MCDC facility and patients | 1st to 3rd Month |
| 2. | Develop comprehensive transition plans | 4th to 6th Month |
| 3. | Implement transition plans | 7th to 11th Month |

1. MCDC | Increase Average Daily Census

**RECOMMENDATIONS**

* Receive patients in facility double rooms.
* Update criteria for admission and discharge to allow for comorbidities and placement within 48 hours.
* Assess census and demand trends to identify other areas of opportunity, including engaging with providers and community partners.

**Benefits**: Better quality care and more effective delivery of treatment by taking full advantage of MCDC’s capacity to serve.

**PRIORITY**

*Opportunity*

*Complexity*

**+**

**+**

**-**

Opportunity: Medium

Complexity: Medium

**ESTIMATED IMPACT**

Benefits: Improve Quality and Effectiveness of Care

One Time Costs: None

Recurring Costs: None

**CONSIDERATIONS**

Risks: N/A

Dependencies: N/A

Resources: Facility leaders

**HIGH LEVEL ACTIVITIES**

|  |  |  |
| --- | --- | --- |
|  | **Activities** | **12-months Duration Timeline** |
| 1. | Conduct patient assessments and transition plans to determine which patients should be moved | 1st Month |
| 2. | Assess current waitlist and develop plans to receive patients | 1st and 2nd Month |
| 3. | Revise facility policies and procedures | 2nd Month |

1. Appendix
2. Appendix A | Geographic Detail: Montana State Hospital Admissions by Commitment Type, July 2021 to June 2022

Below is a breakdown of the commitment types over a year-long period at MSH, including additional data showing a breakdown of commitments by the top 10 counties in Montana.

|  |  |  |  |
| --- | --- | --- | --- |
| **Commitment** | **Commit Type** | **Admissions** | **Average Length of Stay (Days)** |
| Court Ordered Detention | Civil | 408 | 33 |
| Involuntary 90 Day | Civil | 179 | 53 |
| Tribal | Tribal | 84 | 21 |
| Unfit to Proceed | Forensic | 57 | 153 |
| Court Ordered Evaluation | Forensic | 36 | 152 |
| Guilty But Mentally Ill | Forensic | 12 | 190 |
| Emergency Detention | Civil | 11 | 31 |
| Pre-Sentence Evaluation | Forensic | 6 | 268 |
| Institutional Transfer | Transfer | 1 | 154 |
| 10 Day Inter-Institutional Transfer | Transfer | 1 | 9 |
| Not Guilty Mentally Ill | Forensic | 1 | 289 |
| **Subtotals** | **Civil** | **598** | **40** |
| **Forensic** | **112** | **168** |
| **Tribal** | **84** | **21** |
| **Transfer** | **2** | **85** |
| **Total** | **All** | **796** | **55**1 |

*Notes: 1. The average length of stay total was calculated as a weighted average based on the proportion of admissions of that commitment type to the total number of admissions at MSH*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Top 10 Counties** | **Admissions by Commitment Type** | | | | **Total Admissions** | **Population Size**  **(in 1000s)** |
| **Civil** | **Forensic** | **Tribal** | **Transfer** |
| Missoula | 140 | 28 |  |  | 168 | 119 |
| Silver Bow | 108 | 7 |  |  | 115 | 35 |
| Yellowstone | 85 | 11 |  | 1 | 97 | 160 |
| Glacier | 3 |  | 60 |  | 63 | 14 |
| Gallatin | 61 | 1 |  |  | 62 | 111 |
| Lewis & Clark | 37 | 7 |  |  | 44 | 69 |
| Cascade | 20 | 18 |  |  | 38 | 82 |
| Flathead | 23 | 3 |  |  | 26 | 102 |
| Deer Lodge | 19 | 4 |  |  | 23 | 9 |
| Ravalli | 17 | 5 |  |  | 22 | 43 |
| Lake | 15 | 6 | 1 |  | 22 | 30 |

1. Appendix B | Behavioral Health Providers in Montana Today

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Address** | **City** | **State** | **Zip** | **County** | **Provider Type** |
| 3 Rivers Mental Health Solutions | 715 Kensington Avenue | Missoula | MT | 59801 | Missoula | Residential/24-hour residential |
| AWARE Inc Great Falls | 600 6th Street NW | Great Falls | MT | 59404 | Cascade | Residential/24-hour residential |
| AWARE Inc Helena | 616 Helena Avenue | Helena | MT | 59601 | Lewis and Clark | Outpatient |
| AWARE Inc Billings | 1050 South 25th Street West | Billings | MT | 59102 | Yellowstone | Residential/24-hour residential |
| AWARE Inc | 2300 Regent Street | Missoula | MT | 59801 | Missoula | Residential/24-hour residential |
| Big Timber Mental Health Center Office | 515 Hooper Street | Big Timber | MT | 59011 | Sweet Grass | Outpatient |
| Billings Clinic | 2950 10th Avenue North | Billings | MT | 59101 | Yellowstone | Hospital inpatient/24-hour hospital inpatient |
| Bitterroot Valley Educ Cooperative | 300 Park Street | Stevensville | MT | 59870 | Ravalli | Outpatient |
| Braided Circle | 1500 Colburn Road | Billings | MT | 59102 | Yellowstone | Residential/24-hour residential |
| Center for Mental Health Largent Outpatient Services | 915 1st Avenue South | Great Falls | MT | 59401 | Cascade | Outpatient |
| Center for Mental Health New Directions Center | 621 1st Avenue South | Great Falls | MT | 59401 | Cascade | Partial hospitalization/day treatment |
| Center for Mental Health | 900 Jackson Street | Helena | MT | 59602 | Lewis and Clark | Outpatient |
| Center for Mental Health Choteau Center for Mental Health | 1 Main Avenue South | Choteau | MT | 59422 | Teton | Outpatient |
| Center for Mental Health Conrad Center for Mental Health | 514 South Front Street | Conrad | MT | 59425 | Pondera | Outpatient |
| Center for Mental Health Havre Center for Mental Health | 312 3rd Street | Havre | MT | 59501 | Hill | Outpatient |
| Columbus Mental Health Center | 2125 8th Avenue North | Billings | MT | 59101 | Stillwater | Outpatient |
| Eastern Montana CMHC Forsyth Office | 121 North 11th Avenue | Forsyth | MT | 59327 | Rosebud | Outpatient |
| Eastern Montana CMHC Glasgow Office | 1009 6th Avenue North | Glasgow | MT | 59230 | Valley | Outpatient |
| Eastern Montana CMHC Miles City Office | 2508 Wilson Street | Miles City | MT | 59301 | Custer | Residential/24-hour residential |
| Eastern Montana CMHC Wolf Point Office | 124 Custer Street | Wolf Point | MT | 59201 | Roosevelt | Outpatient |
| Eastern Montana CMHC | 507 North Lincoln Street | Broadus | MT | 59317 | Powder River | Outpatient |
| Eastern Montana CMHC Glendive Office | 2016 North Merrill Street | Glendive | MT | 59330 | Dawson | Residential/24-hour residential |
| Eastern Montana CMHC Substance Abuse | 10 West Fallon Avenue | Baker | MT | 59313 | Fallon | Outpatient |
| Eastern Montana CMHC Sidney Office | 1201 West Holly Street | Sidney | MT | 59270 | Richland | Outpatient |
| Eastern Montana CMHC Abuse and Dependency Services | 100 West Laurel Street | Plentywood | MT | 59254 | Sheridan | Outpatient |
| Gallatin Mental Health Center Hope House | 701 Farmhouse Lane | Bozeman | MT | 59715 | Gallatin | Residential/24-hour residential |
| Intermountain Community Services | 3240 Dredge Drive | Helena | MT | 59602 | Lewis and Clark | Outpatient |
| New Day Ranch Inc | 5351 King Avenue West | Billings | MT | 59101 | Yellowstone | Residential/24-hour residential |
| New Day Ranch Inc Mental Health Center | 1724 Lampman Drive | Billings | MT | 59101 | Yellowstone | Partial hospitalization/day treatment |
| New Day Ranch Inc | 1111 Coburn Road | Billings | MT | 59101 | Yellowstone | Residential/24-hour residential |
| Providence Saint Joseph Medical Ctr | 6 Thirteenth Avenue East | Polson | MT | 59860 | Lake | Outpatient |
| Providence Saint Patrick Hospital | 902 North Orange Street | Missoula | MT | 59802 | Missoula | Hospital inpatient/24-hour hospital inpatient |
| PureView Health Center | 1930 9th Avenue | Helena | MT | 59601 | Lewis and Clark | Outpatient |
| Riverfront Mental Health Center West House | 1404 Westwood Drive | Hamilton | MT | 59840 | Ravalli | Residential/24-hour residential |
| Roundup Satellite Mental Health Ctr | 26 West Main Street | Roundup | MT | 59072 | Musselshell | Outpatient |

1. Appendix B | Behavioral Health Providers in Montana Today

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | **Address** | **City** | **State** | **Zip** | **County** | **Provider Type** |
| Safe Haven Home Women and Children | 2115 Canyon Drive | Billings | MT | 59101 | Yellowstone | Residential/24-hour residential |
| Shodair Childrens Hospital | 2755 Colonial Drive | Helena | MT | 59601 | Lewis and Clark | Hospital inpatient/24-hour hospital inpatient |
| South Central Montana Reg MH Center Red Lodge MH and Addiction Office | 10 Oakes Street South | Red Lodge | MT | 59068 | Carbon | Outpatient |
| South Central Montana Regional MHC Lewistown | 212 Wendell Street | Lewistown | MT | 59457 | Fergus | Outpatient |
| South Central Montana Regional MHC Journey Recovery Program | 1245 North 29th Street | Billings | MT | 59101 | Yellowstone | Outpatient |
| St Peters Health Behavioral Health Unit | 2475 East Broadway Street | Helena | MT | 59601 | Lewis and Clark | Hospital inpatient/24-hour hospital inpatient |
| Western Montana Mental Health Center Missoula Adult Services | 1315 Wyoming Street | Missoula | MT | 59801 | Missoula | Partial hospitalization/day treatment |
| Western Montana Mental Health Center Child and Family Services Network | 1305 Wyoming Street | Missoula | MT | 59801 | Missoula | Outpatient |
| Western Montana Mental Health Center Lake House Crisis Facility | 7 13th Avenue East | Polson | MT | 59860 | Lake | Residential/24-hour residential |
| Western Montana Mental Health Center Sanders County Mental Health Center | 602 Preston Avenue | Thompson Falls | MT | 59873 | Sanders | Outpatient |
| Western Montana Mental Health Ctr Gallatin Mental Health Center | 699 Farmhouse Lane | Bozeman | MT | 59715 | Gallatin | Partial hospitalization/day treatment |
| Western Montana Mental Health Ctr Hays/Morris House | 24 East Copper Street | Butte | MT | 59701 | Silver Bow | Residential/24-hour residential |
| Western Montana Mental Health Ctr Butte Childrens Services | 81 West Park Street | Butte | MT | 59701 | Silver Bow | Outpatient |
| Western Montana Mental Health Ctr Psychiatric Services | 81 West Park Street | Butte | MT | 59701 | Silver Bow | Outpatient |
| Western Montana Mental Health Ctr Silver House | 106 West Broadway Street | Butte | MT | 59701 | Silver Bow | Partial hospitalization/day treatment |
| Western Montana Mental Health Ctr Dakota Place | 1273 Dakota Street | Missoula | MT | 59801 | Missoula | Residential/24-hour residential |
| Western Montana Mental Health Ctr | 209 North 10th Street | Hamilton | MT | 59840 | Ravalli | Partial hospitalization/day treatment |
| Western Montana Mental Health Ctr Flathead County Adult Mental Health | 410 Windward Way | Kalispell | MT | 59901 | Flathead | Partial hospitalization/day treatment |
| Western Montana Mental Health Ctr Safe House | 412 Windward Way | Kalispell | MT | 59901 | Flathead | Residential/24-hour residential |
| Western Montana Mental Health Ctr Fox Creek Adult Group Home | 420 Windward Way | Kalispell | MT | 59901 | Flathead | Residential/24-hour residential |
| Winds of Change | 1120 Cedar Street | Missoula | MT | 59802 | Missoula | Outpatient |
| Yellowstone Boys and Girls Ranch Community Based Services | 1732 South 72nd Street West | Billings | MT | 59106 | Yellowstone | Residential/24-hour residential |
| Yellowstone Boys and Girls Ranch Community Based Services | 312 South Pacific Street | Dillon | MT | 59725 | Beaverhead | Residential/24-hour residential |
| Youth Dynamics Inc Great Falls Community Office | 225 7th Avenue | Great Falls | MT | 59405 | Cascade | Outpatient |
| Youth Dynamics Inc Helena Community Office | 1005 Partridge Place | Helena | MT | 59602 | Lewis and Clark | Outpatient |
| Youth Dynamics Inc | 1609 West Babcock Street | Bozeman | MT | 59715 | Gallatin | Outpatient |
| Youth Dynamics Inc Butte Community Office | 775 West Gold Street | Butte | MT | 59701 | Silver Bow | Outpatient |
| Youth Dynamics Inc | 220 3rd Avenue | Havre | MT | 59501 | Hill | Outpatient |
| Youth Dynamics Inc | 1250 15th Street West | Billings | MT | 59101 | Yellowstone | Outpatient |
| Youth Dynamics Inc Shelby Community Office | 222 Main Street | Shelby | MT | 59474 | Toole | Outpatient |
| Youth Dynamics Inc Missoula Community Office | 619 SW Higgins Street | Missoula | MT | 59803 | Missoula | Outpatient |
| Youth Dynamics Inc Kalispell Community Office | 450 Corporate Drive | Kalispell | MT | 59901 | Flathead | Outpatient |
| Youth Dynamics Inc Miles City Community Office | 1200 Pleasant Street | Miles City | MT | 59301 | Custer | Outpatient |
| Youth Dynamics Inc Wolf Point Community Office | 112 Main Street | Wolf Point | MT | 59201 | Roosevelt | Outpatient |
| Youth Dynamics Inc Glendive Community Office | 606 North Merrill Avenue | Glendive | MT | 59330 | Dawson | Outpatient |

1. Appendix C | List of regulations for each Facility

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility** | **License Type** | **License No.** | **Authority and Regulations (Links)** |
| Montana State Hospital  – Main Hospital | Hospital | 12943 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.4](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.4) (Hospitals)  [MCA 50-5](https://leg.mt.gov/bills/mca/title_0500/chapter_0050/parts_index.html) (Hospitals and Related Facilities) |
| Montana State Hospital  – Forensic (Galen and Group Homes) | Mental Health Center | 12910 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.19](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.19) (Mental Health Center)  [37.106.20](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.20) (Mental Health Center-Foster Care)  [MCA 50-5](https://leg.mt.gov/bills/mca/title_0500/chapter_0050/parts_index.html) (Hospitals and Related Facilities)  [MCA 53-21-1](https://leg.mt.gov/bills/mca/title_0530/chapter_0210/part_0010/sections_index.html) (Treatment of Seriously Mental Ill) |
| Montana Mental Health Nursing Care Center | Long Term Care | 13143 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.6](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.6) (Nursing Facilities) |
| Intensive Behavior Center | Intermediate Care Facility for Developmentally Disabled | 12904 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.21](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.21) (ICF / DD) |
| Montana Chemical Dependency Center #1 | Inpatient Chemical Dependency Facility | 13462 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.14](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.14) (Chemical Dependency Facilities) |
| Montana Chemical Dependency Center #2 | Inpatient Chemical Dependency Facility | 13461 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.14](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.14) (Chemical Dependency Facilities) |
| Montana Chemical Dependency Center #3 | Inpatient Chemical Dependency Facility | 13070 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.14](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.14) (Chemical Dependency Facilities) |
| Montana Veterans Home Columbia Falls | Long Term Care &  Retirement Homes | 13517 &  13490 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.6](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.6) (Nursing Facilities)  [37.106.25](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.25) (Retirement Homes)  [MCA 52-3-8](https://leg.mt.gov/bills/mca/title_0520/chapter_0030/part_0080/sections_index.html) (Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act) |
| Eastern Montana Veterans Home | Long Term Care | 13454 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.6](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.6) (Nursing Facilities) |
| Southwestern Montana Veterans Home | Long Term Care | 13594 | [37.106.3](http://www.mtrules.org/gateway/Subchapterhome.asp?scn=37.106.3) (Health Care Facilities)  [37.106.6](https://rules.mt.gov/gateway/Subchapterhome.asp?scn=37%2E106.6) (Nursing Facilities) |

1. Appendix D | Detailed Vacancy and Housing Data, 10-Year Snapshot

There has been an upward trend with both vacancies at state-run facilities and home values in Montana over the last decade. **The greatest increase in both was seen in 2021**, where vacancies at state-run facilities increased by 58.8% and home values increased by 26.8%.

The tables below provide further detail into vacancies over time by facility, as well as the changes in Montana’s home values compared to the national average.

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Vacancy Rate by Facility** | **2010** | **2011** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **2022** | **20232** |
| **Intensive Behavioral Center** | 21.00 | 14.69 | 23.98 | 14.25 | 28.94 | 30.50 | 45.13 | 46.00 | 85.82 | 51.31 | 11.60 | 13.91 | 34.91 | *37.60* |
| **Montana Chemical Dependency Center** | 6.00 | 15.00 | 16.00 | 11.00 | 6.00 | 3.00 | 4.00 | 3.90 | 6.40 | 2.40 | 3.90 | 6.90 | 2.40 | *1.40* |
| **Montana Mental Health Nursing Care Center** | 4.89 | 11.99 | 12.00 | 10.55 | 11.10 | 17.00 | 7.20 | 9.67 | 15.70 | 32.93 | 12.70 | 15.87 | 32.90 | *34.40* |
| **Montana State Hospital** | 27.00 | 37.95 | 30.85 | 24.00 | 12.10 | 12.90 | 39.76 | 46.85 | 51.45 | 72.50 | 93.90 | 159.85 | 228.10 | *234.20* |
| **Montana Veterans Home** | 3.60 | 2.80 | 3.90 | 4.80 | 0.90 | 6.75 | 3.55 | 5.70 | 5.60 | 11.40 | 8.35 | 10.60 | 22.25 | *29.50* |
| **Grand Total** | **63.49** | **83.43** | **86.73** | **64.60** | **59.04** | **70.15** | **99.64** | **112.12** | **164.97** | **170.54** | **130.45** | **207.13** | **320.56** | *337.10* |
| **Percent Change** | *n/a* | **31.4%** | **4.0%** | **-25.5%** | **-8.6%** | **18.8%** | **42.0%** | **12.5%** | **47.1%** | **3.4%** | **-23.5%** | **58.8%** | **54.8%** | *5.2%2* |

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Year** | **2012** | **2013** | **2014** | **2015** | **2016** | **2017** | **2018** | **2019** | **2020** | **2021** | **20224** |
| **United States Avg Home Value3,4** | $167K | $180K | $190K | $199K | $210K | $223K | $237K | $247K | $261K | $311K | $355K |
| **Montana Avg Home Value3,4** | $206K | $216K | $227K | $236K | $243K | $255K | $270K | $285K | $302K | $383K | $453K |
| **Difference in Home Value – MT vs. US**  *(Change in gap from previous year)* | $39K | $36K *(-3K)* | $37K *(+1K)* | $37K | $33K *(-4K)* | $32K *(-1K)* | $33K *(+1K)* | $38K *(+5K)* | $41K *(+3K)* | $72K *(+31K)* | $98K *(+26K)* |
| **Percent Change in Home Value: US** | | 7.8% | 5.6% | 4.7% | 5.5% | 6.2% | 6.3% | 4.2% | 5.7% | 19.2% | 14.1% |
| **Percent Change in Home Value : MT** | | 4.9% | 5.1% | 4.0% | 3.0% | 4.9% | 5.9% | 5.6% | 6.0% | 26.8% | 18.3% |

*Notes: 1. Vacancies for each fiscal year are a point-in-time count from June of each year, with the exception of FY23 (see note below)*

*Bullets for talking points*

* *Geography, other factors*
* *Montana ranks 5th in the nation for the shortage of nurses*
* *Even by raising wages for permanent staff, many nurses still choose to be a traveler*
  + *They are offered free housing and the freedom and flexibility to choose when and where they want to work along with months off between assignments.*
* *Traveler contracts are becoming more competitive.*
* *The national RN turnover rate can be as high as 64%.*
* *The average RN vacancy rate for inpatient behavioral health is higher than other acute care settings and can be up to 65% in some states.*

*2. FY23 counts are as of September 8, 2022*

*3. Source:* [*Zillow Home Value Index*](https://www.zillow.com/home-values/)*, last retrieved September 9, 2022*

*4. Home values are pulled from September of each respective year, with the exception of 2022, where the home value is as of July 31, 2022*

In addition to the average home value increasing in Montana over the last decade, **the gap between home values in Montana and the national average has increased as well**. In 2021, the gap between the Montana and US average value increased by $31,000, and in 2022, the gap increased again by $26,000.

The increased home value and subsequent increased cost of living in Montana presents challenges to recruitment and talent acquisition efforts.

1. Appendix E | Detailed breakdown of incident tracking at facilities (1 of 2)

Below is a breakdown of the method of incident tracking at each facility and which incidents are being tracked – additional incidents are on the next slide.

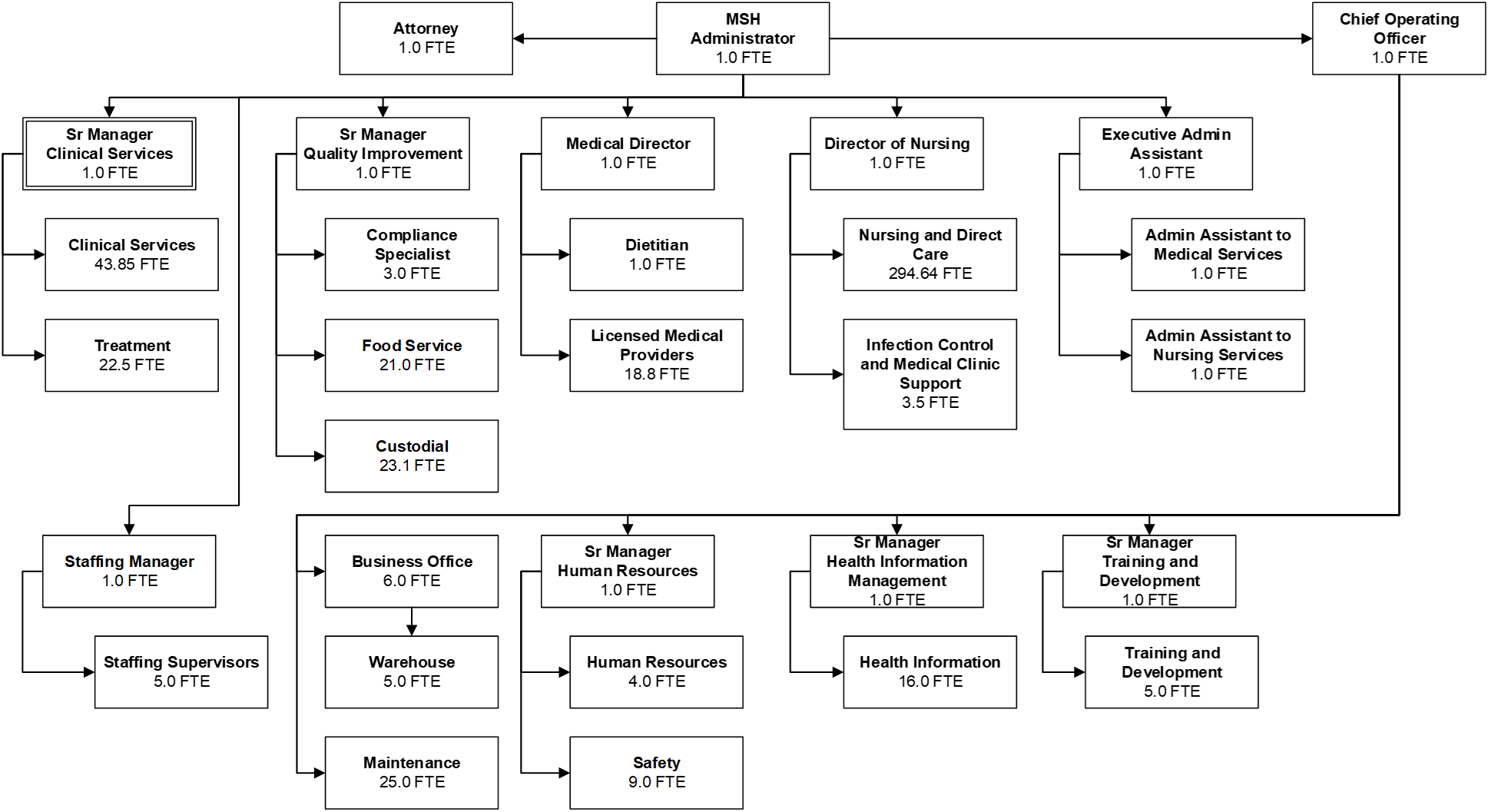
|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility** | **SWMVH** | **MMHNCC** | **MVH-CF** | **EMVH** | **MSH** | **MCDC** | **IBC** | **NUMBER OF FACILITIES REPORTING** |
| **Software for Tracking** | **Whiteboard** | **MS Excel** | **State Online Portal** | **Sanders (EHR); RL Solutions; Stat Online Portal** | **MS Excel, NRI Database** | **MS Excel** | **Therap (GERs)** |
| **Falls** | x | x | x | x | x |  |  | 5 |
| **Elopement** | x |  | x |  | x |  | x | 4 |
| **Medication Errors** |  | x | x | x |  | x |  | 4 |
| **Alleged Abuse, Neglect, Mistreatment** | x | x | x |  |  |  |  | 3 |
| **Infections/COVID** |  | x | x | x |  |  |  | 3 |
| **Injury** |  | x |  | x |  | x |  | 3 |
| **Property Concerns** |  |  |  | x | x | x |  | 3 |
| **Accident, Other Misc.** |  |  | x |  | x |  |  | 2 |
| **Brief Hold** |  |  |  |  | x |  | x | 2 |
| **Care Concerns** |  |  |  | x | x |  |  | 2 |
| **Death** |  | x | x |  |  |  |  | 2 |
| **IM Injection** |  |  |  |  | x |  | x | 2 |
| **Mechanical Restraint (e.g., bed)** |  |  |  |  | x |  | x | 2 |
| **Restraint** |  | x | x |  |  |  |  | 2 |
| **Self-Inflicted Injury** |  |  |  |  | x |  | x | 2 |
| **Sexual Behavior** |  |  |  |  | x |  | x | 2 |
| **Violence/Aggression** |  |  |  |  | x |  | x | 2 |
| **Assault, Homicide** |  |  | x |  |  |  |  | 1 |
| **Burn** | x |  |  |  |  |  |  | 1 |

1. Appendix E | Detailed breakdown of incident tracking at facilities (2 of 2)

Below is a breakdown of the method of incident tracking at each facility and which incidents are being tracked – continued from the previous slide.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility** | **SWMVH** | **MMHNCC** | **MVH-CF** | **EMVH** | **MSH** | **MCDC** | **IBC** | **NUMBER OF FACILITIES REPORTING** |
| **Software for Tracking** | Whiteboard | MS Excel | State Online Portal | Sanders (EHR); RL Solutions; Stat Online Portal | MS Excel, NRI Database | MS Excel | Therap (GERs) |
| **Clinical Intervention** |  |  | x |  |  |  |  | 1 |
| **Contraband** |  |  |  |  | x |  |  | 1 |
| **Exposure to Blood or Body Fluid** |  |  |  |  | x |  |  | 1 |
| **Fecal Hoarding/Smearing** |  |  |  |  |  |  | x | 1 |
| **Fire or Environmental Emergency** |  |  |  |  | x |  |  | 1 |
| **Hospital Stays** |  | x |  |  |  |  |  | 1 |
| **Lost Resident Items** |  | x |  |  |  |  |  | 1 |
| **Other** | x |  |  |  |  |  |  | 1 |
| **Other Disruptive Behavior** |  |  |  |  |  |  | x | 1 |
| **Pica** |  |  |  |  |  |  | x | 1 |
| **Property Destruction** |  |  |  |  |  |  | x | 1 |
| **Resident to Resident Event** | x |  | x |  |  |  |  | 1 |
| **Seclusion** |  |  |  |  | x |  |  | 1 |
| **Skin Tear/Bruise Unknown Origin** | x |  |  |  |  |  |  | 1 |
| **Skin Wound** |  |  |  | x |  |  |  | 1 |
| **Suicidal Ideation** |  | x |  |  |  |  |  | 1 |
| **Suicide, Suicide Attempt** |  |  | x |  |  |  |  | 1 |
| **Suspicion of a Crime** |  |  | x |  |  |  |  | 1 |
| **Transport Blanket** |  |  |  |  | x |  |  | 1 |
| **Unsafe Smoking** |  |  |  |  | x |  |  | 1 |
| **Verbal Aggression** |  |  |  |  |  |  | x | 1 |

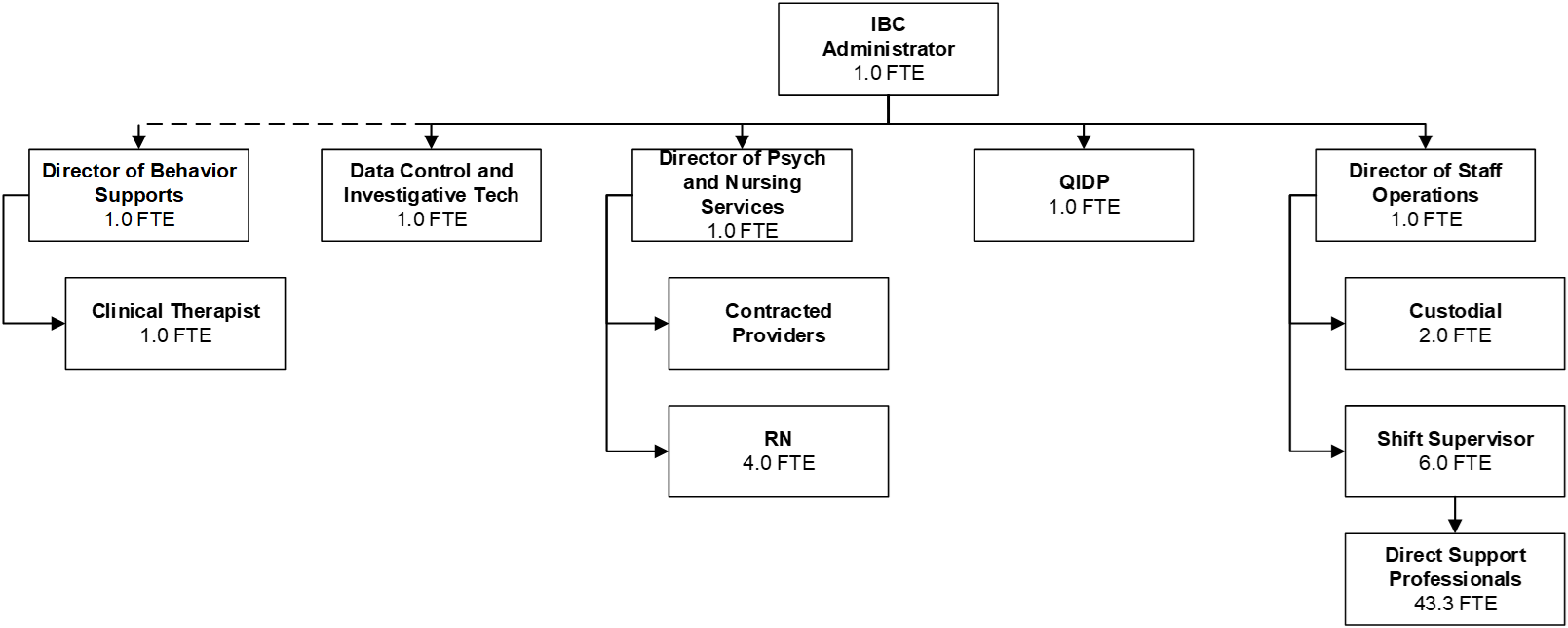
1. Appendix F | Montana State Hospital: Organizational Structure

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1. Appendix F | Montana Mental Health Nursing Care Center: Organizational Structure

**Organizational flowchart depicting the hierarchy of Montana Mental Health Nursing Care Center**

1. Appendix F | Intensive Behavior Center: Organizational Structure

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1. Appendix F | Montana Chemical Dependency Center: Organizational Structure

**Organizational flowchart depicting the hierarchy of Montana Chemical Dependency Center**

1. Appendix F | Montana Veterans’ Home: Organizational Structure

**Organizational flowchart depicting the hierarchy of Montana Veterans’ Home**

1. Appendix G | Census, Admissions, Discharges, and Waitlist Numbers

Below is a breakdown of the average daily census (%), and the number of admissions, discharges, and individuals on the waitlist for each of the seven facilities, from May to September 2022.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Month** | **Facility** | **Average Daily Census %** | **Admissions** | **Discharges** | **Waitlist** |
| **May** | **MSH** | 70% | 54 | 59 | 40 |
| **MMHNCC** | 59% | 2 | 1 | 0 |
| **IBC** | 75% | 0 | 0 | 0 |
| **MCDC** | 27% | 21 | 30 | 15 |
| **CFMVH** | 55% | 0 | 1 | 203 |
| **SWMVH** | 86% | 2 | 3 | 31 |
| **EMVH** | 71% | 9 | 3 | 0 |
| **June** | **MSH** | 73% | 56 | 48 | 38 |
| **MMHNCC** | 58% | 1 | 3 | 0 |
| **IBC** | 75% | 0 | 0 | 0 |
| **MCDC** | 44% | 30 | 18 | 0 |
| **CFMVH** | 56% | 3 | 1 | 198 |
| **SWMVH** | 94% | 1 | 1 | 40 |
| **EMVH** | 73% | 4 | 3 | 0 |
| **July** | **MSH** | 74% | 58 | 44 | 44 |
| **MMHNCC** | 57% | 3 | 1 | 3 |
| **IBC** | 75% | 0 | 0 | 0 |
| **MCDC** | 46% | 23 | 36 | 0 |
| **CFMVH** | 55% | 0 | 1 | 196 |
| **SWMVH** | 77% | 6 | 3 | 32 |
| **EMVH** | 73% | 3 | 2 | 0 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Month** | **Facility** | **Average Daily Census %** | **Admissions** | **Discharges** | **Waitlist** |
| **August** | **MSH** | 73% | 50 | 60 | 39 |
| **MMHNCC** | 58% | 0 | 2 | 4 |
| **IBC** | 75% | 0 | 0 | 2 |
| **MCDC** | 38% | 33 | 28 | 0 |
| **CFMVH** | 53% | 0 | 0 | 196 |
| **SWMVH** | 75% | 8 | 4 | 34 |
| **EMVH** | 73% | 4 | 3 | 0 |
| **September** | **MSH** | 74% | 76 | 50 | 42 |
| **MMHNCC** | 57% | 2 | 0 | 3 |
| **IBC** | 83% | 1 | 0 | 3 |
| **MCDC** | 32% | 29 | 25 | 0 |
| **CFMVH** | 53% | 2 | 2 | 204 |
| **SWMVH** | 72% | 3 | 1 | 32 |
| **EMVH** | 73% | 4 | 6 | 0 |

1. Back Page

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